DOCUMENT RESUME

ED 149 539	EC 103 855

AUTHOR	Wawrykow, George M.
TITLE	Special Services to Children with Special Needs.
INSTITUTION	Gulf Coast Community Services Association, Houston, Tex.
PUB DATE	77
NOTE	153p.; Not available in hard copy due to marginal legibility of original
EDRS PRICE	MF-$0.83 Plus Postage. HC Not Available from EDRS.
DESCRIPTORS	Administration; Cooperative Programs; Early Childhood Education; *Handicapped Children; Language Development; Preschool Education; Psychological Services; *Regional Programs
IDENTIFIERS	*Project Head Start

ABSTRACT

Presented are 18 papers developed by the Gulf Coast Consortium and intended to provide documentation of Head Start services to handicapped children. The first three papers provide an overview of the consortium with emphasis on the impact of Head Start programs on the language learning disabled child. Eight papers focus on the use of psychological service consultants in specific programs and the need for a research and evaluation component in the Head Start delivery system. Three papers concern speech, hearing, and language services. Four papers are written by Head Start directors and consider organizing, planning, and implementing a Head Start program for handicapped children. (DB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED149539

SPECIAL SERVICES TO CHILDREN WITH SPECIAL NEEDS

George M. Wawrykow

Gulf Coast Consortium

BEST COPY AVAILABLE

"PERMISSION TO REPRODUCE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY
G. WAWRYKOW

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC) AND USERS OF THE ERIC SYSTEM."

BEST COPY AVAILABLE

EC 103 855

1977

Gulf Coast
Community Services Association
6300 BOWLING GREEN HOUSTON, TEXAS 77021 713-748-4410

EXECUTIVE DIRECTOR
Mario D. Silva

Director, Head Start
Ruth J. Marshall

2- 3-4

PREFACE

While to date 59 research reports have been published on Head Start, Head Start has not been adequately evaluated as a comprehensive services program (Mann, Harrell, & Hurt, 1977). Yet, Head Start is, and has been a demonstration project. One of the most productive aspects of Head Start has become one limiting factor. Head Start has encouraged the developmental unfolding of the child and his family. Through a "bootstrap" effect, families have acquired skills and moved on to become productive members of society. These families' skills are lost to Head Start. Head Start has deilived...Service. Unfortunately, because research and development components are absent in most Head Start agencies, these gains for the children or their families could not be documented. Because it was felt to be crucially important to begin this documentation and reporting procedure, and because the Head Start Staff and their consultants were excited about the Special Services component in our consortium, the consortium coordinator was asked to draw together invited reports on various aspects of the program. Submissions were received from most programs and consultants. They represent hours of diligent work, many hours of evenings and weekends "bootlegged" by already overburdened underpaid persons who believe in the importance of Head Start.

This collection of papers must be dedicated to those persons who have given so extensively of their energies and time on behalf of children and families during Head Start's first decade, and to those who now, excited about a new development of Head Start, have spent extra time of their own and documented as best they could the development of Special Services for the Handicapped in Head Start.

The papers reflect a depth of insight and a degree of success with Head Start that comes only with intimate understanding of the goals and the programs. The eagerness to dare to share, relates to their belief that what they are doing is substantive; that they are having a very positive impact on the children and their families. The written results are limited only by administrative, research, demonstration funding. Perhaps the next step is to formalize these efforts and make the Gulf Coast Consortium for Special Services a Research and Demonstration Project.

George M. Wawrykow

George M. Wawrykow, Ph.D
Coordinator of Special Services
Gulf Coast Consortium

7/23/77

GMW:ngs

TABLE OF CONTENTS

AN OVERVIEW

The Gulf Coast Consortium: Delivering Special Services in Head Start.

Impact of Head Start Handicapped Programs on the Language Learning Disabled Child....

Facilitation of Learning and Mental Health....

MENTAL HEALTH

A Peplicable Model for Immediate Intervention on Behalf of Handicapped Children.

Psychological Techniques and Procedures Employed for Use With Handicapped Children in Head Start.

Head Start Psychological Consultation: A Progress Report.

A Center-Based Model for Consultation Relating to the Handicapped Child.

Psychological Consultation: Texas City.

Psychological Consulting Activities: Abell Street School.

Head Start Psychological Consultation Services: Report and Recommendations: Brazosport.

Proposed Evaluation of Head Start Services to Handicapped Children.

SPEECH, HEARING, AND LANGUAGE

Head Start and Speech/Hearing/Language Services-Lamar University.

Head Start: Speech/Hearing/Language Services: Galveston County.

Speech Hearing and Language Services to Head Start in Brazoria County.

ADMINISTRATION AND THE SOCIO-CULTURAL IMPACT

Administering a Local Handicapped Program.

Helping the Handicapped: A Developmental Assistant.

Central Day Care Association: Head Start Handicapped Services.

Selected Professional and Socio-Cultural Effects of the Handicapped Services Project on the Alabama-Coushatta Indian Reservation Head Start Program.

INTRODUCTION

The present collection of papers is comprised of submissions of various levels...each excellent. It is meant for sharing, not only among delegate agencies and consultants within our consortium, but with regional consultants, T/TA providers, National Head Start Administrators and other Consortia for Handicapped Services in Head Start. It is the hope of Gulf Coast Consortium members and of our consultants that we can help each each other, by sharing our innovations, to reach new heights on behalf of our children.

The first three papers deal with an overview of the consortium. The first explores the best of what we are, adds up these individual perceptions to formulate principles for working with the handicapped in Head Start. The second paper draws together past research to develop a processing model for childhood processing and language development. The third paper draws together what we know about facilitating processing, language acquisition, growth and development.

The second set of papers is concerned with use of psychological services consultants. Psychological Services to each of several programs are described. Additionally, the last paper in this section is a proposal for incorporating a research and evaluation component into our delivery system.

The third set of papers concern speech, hearing and language services. The first is a position paper developed by Lamar University Speech and Hearing Center. It is followed by reports by other specific consultants.

The final section contains papers written by Heart Start Directors. Organizing, Planning, Implementing a program and the effects of local programs are discussed.

SPECIAL SERVICES TO CHILDREN WITH SPECIAL NEEDS

AN OVERVIEW

SPECIAL SERVICES TO CHILDREN WITH SPECIAL NEEDS

A CONSORTIUM APPROACH

George M. Wawrykow, Ph.D.
Coordinator of Special Services
Gulf Coast Consortium

Paper presented at the Region V1
Westinghouse Electric Corporation
Health Systems Handicap Conference / Workshop, September, 1977
Northpark Inn, Dallas, Texas.

EARLY CHILDHOOD LEARNING AND MENTAL HEALTH

What are the meaningful questions? What is Head Start? What is our purpose in Head Start? What are our goals in working with the Handicapped in Head Start?

The principle aim of the Gulf Coast Consortium is to give each child a Head Start, regardless of ethnic origin, social status or handicapping condition.

> "Just like a rose needs Nurturance, Love and Care
> to aide its Developmental Unfolding...
>
> Each child needs our Nurturance, Love and Care
> to aide his Developmental Unfolding."

Each child needs to be able to process information. To do this, he needs to be facilitated in Affective, Behavioral and Cognitive Domains, affect being especially important for learning in Head Start stage children (Wawrykow, 1975). During the stage of direct action, the behavioral domain appears to be dominant; during the pre-operational stage, the affective appears dominant; and during the subsequent stages, cognition seems to become dominant. It may be that if a child does not learn to use a particular domain during the appropriate stage, that a processing, and hence learning difficulty, possibly extensive enough to be declared handicapping, occurs.

THE GULF COAST CONSORTIUM AS A DEMONSTRATION PROJECT

Through the consortium, a large umbrella for the provision of services was created. The consortium provides a means for the Gulf Coast Head Start programs to receive at least minimally effective, and in many cases, exemplary service regardless of:

1. Size of program.
2. Distance of delegate agency from services.
3. The nature of the handicapping condition.
4. The quality and quantity of service the year previous.
5. The degree of sophistication of the Head Start directors and their staff, and families concerning special service to the handicapped.

A needs assessment was informally completed on each program and concurrently on each of the potential service providers. While during the early stages in many of the programs, the coordinator assumed much of the responsibility, the goal was, by year end, for each agency to assume a great deal of the responsibility for its own special service program.

The major initial objective was to maximize the follow-up service to each child in need; to give each as much of a true Head Start as possible. Time was at a premium because of the late date at which the fundings were received. Thus, provision of services was emphasized, to enable each child to have a true Head Start. The staff and parents began to realize a need for continuing education, and this became an objective for the year.

Furthermore, such excitement was engendered among directors, staff and families (as evidenced among other indicators, by the influx of highly complimentary mail which was received), that more sophisticated questions about (a) the process and (b) the outcome for children, staff, and families resulting from special services became topics for discussions and exploration. The participants truly began to view the consortium as a demonstration, and were justifiably proud of their special programs. The coordinator has been asked by most of the consortium delegate agencies to pursue for the 1977-1978 year, possibilities for establishing this consortium as a demonstration project. The concepts of the developmental assistant, the use of student-help, the means of administrating, managing, and consulting within the consortium, the diplomatic manner of acquiring service through establishment of personal relationships have been posed as reasons for development of this consortium into a demonstration project. Lastly, and perhaps most importantly, the systematic recognition and attack of the problems of language learning (processing) disability, the importance of developing special cost effective programs for these children, and the development of various model variations this year to teach processing to Head Start children has been suggested as reasons for the Gulf Coast Consortium becoming a demonstration and researched project. The Head Start Handicapped Consortium could effectively, formally deal with the following research approaches to language:

Development of Core Capability:

a. Cost effectiveness of the various approaches.

b. Mobilization of resources.

c. Managing, and administering a handicapped Consortium.

d. Development of In-service Programs for staff.

Relationship of Early Prevention and Intervention to School Success:

e. The relationship of language learning disability in early childhood with reading disability.

f. School failure.

g. Placement in special classes and early school drop-out.

DEMOGRAPHY OF THE GULF COAST CONSORTIUM

The Gulf Coast Consortium, containing over 3000 Head Start positions, is very representative of a full range of Head Start Programs. Within this consortium are, among the largest (Harris County, 1700 positions), the smallest (A/C Tribal Council, 33 positions), and several intermediate sizes of Head Start programs. Programs within the consortium serve a metropolitan (Houston and Harris County, fourth largest in the Nation), a large city (Beaumont), small cities (Port arthur, Galveston, Texas City), towns (Angleton, Freeport, Hitchcock, Bay City, Wharton, Sugarland), and isolated villages (A/C Reservation).

The Head Start programs are operated by a full variety of agencies, including C.A.P. operated (Harris County); Golden Triangle Child Development Centers (Beaumont, Port Arthur); Economic Action Council (Bay City, Sugarland); private non-profit agencies (Central Day Care--Galveston); school districts (Beaumont I.S.D., South Park I.S.D., Port Arthur I.S.D., Texas City I.S.D., Hitchcock I.S.D., Brazasport I.S.D., Wharton I.S.D. and an Indian Reservation, Alabama/Coushatta Tribal Council.

Sophistication of staff for working with children needing special services also varied...from an absence of special skills, understanding and/or past experience...to a minimum of skills and experience in most programs...to a developed program with in-house professional staff in one agency. The consortium posed most of the unique problems to be experienced by any other consortium. Solution to the problems, development of models provided unique experiences in a cross section of situations representative of other consortia.

PREVALENCE OF HANDICAP

Within the consortium, prevalence of handicapping conditions among Head Start children varies from 12 percent to 56.7 percent, with the consortium average being 17 percent. Factors contributing to these prevalence rates include real differences in incidence, extent to which outside consultants were employed to complete screenings and diagnosis, screening and diagnostic instruments and procedures used, competence of staff in working with children with special problems, willingness to "label" (field specialization of the professional consultants) children as handicapped, professional extent to which labeling could be maintained as an administrative procedure, and the "label" kept apart from the child. It was our collective experience this year that real differences in incidence were less influential than the latter reasons.

SEVERITY OF HANDICAP

The majority of handicapping conditions identified for administrative purposes were of mild and moderate degree (90 percent). Prevalence rates decreased with increasing severity: mild, 51 per cent; moderate, 39 per cent; severe/profound, 10 per cent of total number of funded positions. The statistical expectancy would predict a relatively higher ratio of milds to moderates than was obtained. This departure from the expected was due to the reluctance of personnel to label a child as handicapped, even if this label was to be used only for administrative purposes. As a Head Start program is individualized and personalized for each child regardless if handicapped or not, administrative labels were attached only where necessary.

NATURE OF HANDICAPS

Prevalence rates for each category of handicapping condition were as follows: communication disorder, 53 per cent; specific learning disability, 16 per cent; health and/or developmental impairment, 12 per cent; hearing impairment, 8 per cent; and emotional disturbance, 16 per cent. The prevalence of mental retardation and visual impairment were 2 per cent; blindness, less than 1 per cent; and no deaf children were served. The expectancy rate for communication disorder, for the population at large, is about five per cent. The discrepency between this expectancy and the high rate which was found was thoroughly examined by all professional consulting staff, together with the Head Start Staff under the direction of the coordinator of special services. The results of this scrutiny are presented in two of the papers accompanying this report. Approximately 45 per cent of handicapped children (n = 400), or 11 per cent of all Head Start children have what was called a mild to severe language learning disability (L.L.D.). This category excluded those for whom English, as a second language, was the major problem. Into which category a particular child was diagnosed depended on the professional background of the consultant: physicians tended to diagnose such children developmentally impaired; psychologists, learning disability or emotional disturbance; speech pathologists, communication disorder. The main concern for planning for these children was that they improve their verbal symbolic skills sufficiently so that the lack of language skills would not pose an immediate impediment to learning, and later to learning development and academic success. It would seem that the Gulf Coast Consortium was able to target a primary area, language learning disability, in which Head Start Handicap programs could maximally impact Head Start children, employ a mainstreamed approach for these handicapped youngsters, capitalizing on parent education and involvement, and be a source of new skills to the staff for aiding the teacher in working with regular Head Start children, many of whom do have language learning disabilities of a very mild to mild nature.

MODEL OR MODELS

This past year, a needs assessment was completed informally with each cooperating grantee and each delegate agency within the Consortium. Concurrently, each community was canvassed and an assessment of potential sources of consulting service was made. For the most part, these assessments were also completed informally. By matching consultant resources and their needs with Head Start agencies' needs (and resources), programs for the handicapped were individualized to the agency, and for each child within the agency. It appears that this:

1. responsiveness to need,
2. personalization of handicap programs in terms of needs and resources have been sources of success. This procedure resulted in several personalized, tailored models rather than a Consortium-wide model. The following principles were operative across development and implementation of each program model:

PRINCIPLES:

1. Emphasis On Follow-Up Services	*If:*	provision of the special follow-up services is set as the primary goal, no matter what else is done
	Then:	each child will receive the special services which he needs, no matter what else transpires in the program
	So That:	he can and will acquire the necessary skills to give him a true "Head Start".
2. Bring Services To The Children	*If:*	(a) programs with no services are attended to before programs with preliminary programming, and these are attended to before those with extensive programming (b) community resources are sought locally; only if local resources are not available, are they sought from distant sources (c) consultation is provided to the smaller programs before the larger programs (d) services are brought to the children, rather than children to the services (e) diagnostics are employed to provide directionally for provision of follow-up services for each child

(f) the constant focus and emphasis is on provision of follow-up services to the children

Then: (a) by the end of the year, each program in each delegate agency, will be receiving at least minimally effective resource programming
(b) ties will be fostered between various community resources and Head Start
(c) experience gained with the smaller, more simplistic, programs can be employed in planing and implementation of services to larger programs
(d) the diagnostics, both functional and formal, will be accomplished in the non-threat, naturalistic atmosphere to which the children are accustomed
(e) the diagnostic process will be viewed as a means rather than an end; will be on-going rather than terminal, and will consume a smaller portion rather than the majority of the time of the consultants or staff
(f) each child will be assured of receiving at least minimally effective programming and follow-up service

So That: (a) in succeeding years, children with special needs can receive increased amounts of time and help from regular staff, and parents
(b) by the third year, the sophistication of staff, parents, and consultants will facilitate --evaluation and research--to even further enhance their skills of facilitation of the handicapped, and those working with them.

If: (a) Head Start has a very limited budget
(b) Head Start is to provide a true "Head Start" to children with special problems

Then: (a) local resources will be prioritized as to ability to provide quantity and quality service, i.e. (highest to lowest priority) student-help, public agency, new graduate, new practice, private non-profit, private profit
(b) local resources must be chosen on ability to provide a minimally large quantity of service while meeting minimally effective standards of quality

So That: each "Head Start" program will have truly "cost effective" services.

3. Strive for Responsible Autonomy

If:

(a) a delegate agency has limited in-house expertise for delivery of special services to the handicapped

(b) delegate agency staff have limited experience and little formal education in providing services to the handicapped

(c) our goal is to encourage each delegate agency to become autonomously responsible for provision of special services

Then:

(a) the coordinator of special services will aide that program in developing in-house expertise and decreasing full dependence on the community resources and the coordinator

(b) the coordinator will help the consultants to aide the staff of the delegate agency to acquire the experience, informal and even formal education

(c) in subsequent years, the local delegate agency will build up its core capability, expertise to enable it to accept the responsibility to accompany that authority which has been mandated for provision of special services

So That:

each Head Start delegate agency is able to readily, functionally diagnose, prescribe psycho-socio-medical-educationally and to translate these prescriptions into appropriate classroom and home activities to facilitate actualized learning growth and development of each exceptional child.

Method:

(1) Head Start Programs associated with I.S.D.'s are encouraged to mutually benefit by sharing of expertise with Early Childhood Special Education. While Head Start Director and Staff have skills in the naturalistic developmental approach, the Special Education staff have expertise in compensatory remedial education

(2) Acquisition of in-house staff, such as a developmental assistant in smaller programs, special services consultants in medium-sized programs and full therapeutic teams; comprising mental health, speech hearing and language, and medical specialists in large programs

(3) These professional positions can be both a source of revitalizing expertise for inbred programs and a means to upward mobility for staff already in the programs. Through graduate practicums, interships and post graduate clinical hours, staff that are valuable to Head Start can be educated to new levels and their skills be employed by (rather than lost to) Head Start programs.

4. Initiate Innovation Responsibly

If: (a) the first year, efforts are concentrated on case-centered and program consultation; the staff and parents are able to accept the responsibility for delivery of service in the second year
(b) the first year budget, contracts and resource relationships are carefully developed through extensive methodical efforts, they will require only minor modifications for the second year

Then: in subsequent years, more of the on-going responsibility for coordinating can/will be assumed at the local cooperating grantee and delegate agency level

So That: by the end of the second year, efforts could be focused on research, evaluation, and demonstration. The usefulness of the various services could be demonstrated, indicating which innovations lead to which changes, facilitating administrative decisions. This will give a substantive basis for maturing Head Start from demonstration status to the status of a stable, acceptable, and proven program which has come of age.

By evaluating and researching at the local level, results idiosyncratic to a particular program will be collected. The resulting feedback could be used as an on-going method of improving the program as well as demonstrating efficiency for congress.

To be sure, Training, Continuing Education and Research Personnel, are not readily available in all consortia. Within the Gulf Coast Consortium, the necessary skills to deliver training and grass-roots research of the nature described above, does exist. The role of the Coordinator of Special Services could be broadened to also include Coordinator of Training and Research.

Lamar University, University of Houston, and U.T.M.B., Galveston, have indicated an interest in cooperating in such a venture. The Texas Research Institute of Mental Services has indicated an interest in cooperatively employing the Training and Research Director.

5. Designate Case Managers

If: (a) only those professionals (consultants, staff) and parents who are most directly involved, and are needed, are present at staffings, or become involved with provision of special follow-up for a particular child
(b) each child is not to be lost as a statistic, but is to receive personalized follow-through with coordinated and complimentary efforts of consultants, staff and family
(c) direct Follow-up Service is to be rendered without delay to maximize the impact of this service for the child

Then: for each child, a case manager is designated who is responsible for coordinating efforts for a particular child

So That:
(a) staff and consultants quickly learn each others' capabilities
(b) consultant time is not wasted
(c) the program for each child will be high quality, have continuity, provide service of at least minimal quantity and hence, be Cost Effective.

Method: After initial Head Start screening, the teacher, aide, and Center Director/or developmental assistant/or various consultants, determine in which professional domain the case could be considered. In many cases, the teacher can become case manager; in others, the Center Director; in still others, the educational coordinator, or a nurse, etc. Each could call on one or more of the additional persons as he or she deemed necessary. It is important that consultant time be called on only when needed; but that someone accepts responsibility for the planning and implementation of the plan for each child.

6. Functional Diagnosis, Service and Formal Diagnosis

If: Head Start Staff
(a) have a strong basis in child development
(b) complete the Head Start designated screenings in health and development within six (6) weeks of the child's entry into Head Start
(c) have the knowledge of childhood learning, growth, and development
(d) the skills to facilitate children in their developmental unfolding
(e) asks for and receives consultation from an appropriate professioanl if the child appears regularly not to perform at the level which he is able (his estimated current potential)
(f) holds either a formal or informal staffing
(g) personalizes for each child a psycho-socio-medical-educational plan, at least informally (and preferably, in writing)
(h) designates a case manager for each child
(i) actively involve the parents by first meeting them at the level at which they are able to be involved

Then: (a) a Functional Diagnosis, in terms of strengths and weaknesses, what the child can and cannot do ...in terms of the processing model...as well as a set of suggestions (the plan "g" above) will be readily available for each child

(b) each child can receive follow-up services immediately upon placement in the program

(c) the staff of a program can receive immediate relief in the classroom, the parents the same at home through implementation of the functional diagnostic plan

(d) the child can be further observed in an on-going focused, systematic fashion by staff, parents and consultants as they work with the child, yielding continuous revisions of both the functional diagnosis and the "plans" for the child

(e) the Formal Diagnosis, following an extended period of such observation and intervention will be much more accurate

(f) the Formal Diagnostic label becomes relevant for administrative purposes only

So That: (a) the child receives immediate focused attention (primary and secondary intervention, even secondary and tertiary prevention) without having to be labeled, or at least dealt with, in terms of the potentially damaging, and a functionally not too useful, label

(b) parents are more likely to view Head Start and the Special Services to be positive, helpful and actively yearn to participate to aide their children to developmentally unfold.

7. Facilitate Processing: Reception, Understanding, and Expression

If: (a) a child's difficulty in processing is evident in his lack of oral communication and/or his ability to learn, one or more of the...

(b) receptive (input), associative (integration), and/or expressive (output) processing difficulties are exhibited by substantial numbers of children within a delegate program

(c) language processing difficulties in early childhood are known to be very highly correlated to reading disabilities, learning disabilities, school failure and drop-out rate in later school

(d) Head Start families and program staff are not accustomed to providing language experiences to accompany the wealth of non-verbal experiences

(e) a Head Start program desires to offer effective amd efficient special services

(f) the Head Start program is truly "family" oriented and "developmental" in nature

Then: (a) the child will require special facilitation for using language to process information and thereby learn how to learn

(b) a main goal of the program will be to build in special ways and means of facilitating these large groups in these processing skills which are the building blocks of learning

(c) the language processing skills can be acquired before school entry

(d) language experience programs will be built into the aspects of the Head Start programming including:

1. for the children: all regular learning center individual work experiences, all regular group learning experiences, special activities and core lessons in numbers, science history and culture
2. for the staff, in-service and continuing education on how to use the "language experience" approach
3. for the parent, parent involvement in these activities by telling, showing, and most importantly, participatory-doing

(e) a proportionately large core of special services will be devoted especially to speech, language, learning disabilities, developmental delays, and other categories which are directly affected by normal processing and learning

(f) much of the language processing experience can be acquired through a naturalistic process whereby children are encouraged to verbalize about naturalistic experiences which they are enjoying and have been an integral part of Head Start

So That: each child will receive at least an "even", if not a Head Start, to help prevent Learning and school problems in reading, writing, and arithmetic, placement in special education, early drop-out and delinquency.

To be sure, the emphasis of the Gulf Coast Consortium has been to facilitate the "Developmental Unfolding of each Child and His Family" The focus of our efforts are summarized in the following poem, which was written for, and performed as a vignette at the Regional Conference for Educators of Handicapped Children in Head Start, Dallas, Texas, Spring-1977.

My name is Janis

I am a child...

I have no care,

I touch, I see, I smell the air

Every day in the Sun

I play, I jump, I run

Boy, that's fun

I say just what I want...

I ask

Who?...What?...How?...Why?...

I begin to think...or...at least...I try.

My name is Brad
I...too...am a child...
I...have...a care,
I cannot touch, my hands are limp
and...
When I look...people say I stare.

I'm Evelyn
I'd like to play...
But...
I have to stay home and tend my
sister, every day.

I'm Willie
When my Mommy comes home, she can't tell my sister and me...
Who?...What?...How?...or Why?...You see...
Because she's so tired...from trying to make money...
So...
I get to school, and I'm told I can't think,
I want...
I need a Head Start...please don't let me sink!

IMPACT OF HEAD START HANDICAPPED PROGRAMS
ON
THE LANGUAGE LEARNING DISABLED CHILD

George M. Wawrykow
Coordinator of Special Services
Gulf Coast Community Services
Houston, Texas

Paper presented as part of panel and workshop entitled "Operation Cooperation: A Replicative Model" at the National Office of Child Development Conference, May,1977, El Paso, Texas.

IMPACT OF HEAD START HANDICAPPED PROGRAMS ON THE LANGUAGE LEARNING DISABLED CHILD

George M. Wawrykow, Ph.D.
Coordinator of Special Services
Gulf Coast Handicap Consortium
Houston, Texas

The handicapped children in Head Start are primarily children who have difficulty processing information, having receptive, associative, and or expressive difficulties most noticably in language areas. These are the children, who without intervention would be in the lower group in grade one, the raven or buzzard group in grade two, be failing, and by middle elementary age would be enrolled in special education, and perhaps later be drop outs. What have these children missed? An examination of research on normal development yields suggestions as to what was missing. For the most part these children have good clothing, nice red wagons and little trikes. They have parents who do not have or who are not able to spend time with their children. That is not to say the children have a dearth of experience, they have a wealth of experience. They don't have the concurrent verbal experiences to go along with their non-verbal experiences. They miss the opportunity of using language to systematize their perceiving, to help them form associations, and of course the experiences verbally expressing themselves.

This above description is not intended to imply that Black Dialect or Spanish or any of the Indian Dialects are inferior to the Middle Class English language. Rather, Head Start parents in their homes partly because of culture, partly because of other pressing needs are not able to spend time with their children. In turn they acquire less language symbolism through which children learn to systematize their perception, their associations and their expressions.

Consider the upper class boy who has a governess verbalizing for him as he plays with his cars.

"Boy look at this car go! Wow, sure are a good driver! Rm! Rm! Driving down the road."

Picture the middle class mother who is home baking with her daughter:

"Right crack the egg - like this. Um Hm then put in the yolk. Yes, the yellow part. Um hm, then stir. Good, then get the sugar..."

Since resources, both financial and trained human resources are scarce in Head Start, it seems reasonable to take the children with handicaps (potential) whom we can serve more than adequately with our given resources, the child with Audiological Impairment, Communicative Disorder, Specific Learning Disability or Health and Developmental Impairment. These are children with processing difficulties, which if left unattended, would lead to later problems in school. The Head Start Handicap program offers a developmental milieu, a mainstream experience, and through the Handicap Grants, the service and training for staff and parents to make a positive difference in the lives of these children.

Development of Processing and Language

Each child needs to be facilitated in his processing in three domains, affective, behavioral, and cognitive, affect being especially important in young children (Wawrykow, 1975).

The newborn infant operates through primarily two processes, reception and expression (Gesell & Thompson, 1934; Sherman & Sherman, 1925; Zubeck & Solberg, 1954); in a stage of direct action)Piaget, 1964). The young child who is verbally communicative begins to mediate perception and response through an association process (Osgood, 1957a, 1957b) which is preoperational (Piaget, 1964). These processes continue to be important psycholinguistically (Diebold, 1956; Kirk & McCarthy, 1961) and cognitively (Osgood, 1959; Osgood & Sbeok, 1965) throughout the subsequent stages of growth and development, which include Concrete Operations and Formal Thought.

During the stage of direct action the child enjoys only primitive cognitive (representational) and affective development. Both the use of affect and representational cognition undergo rapid development during the preoperational stage. It has been recognized that the affective component is most important for learning and cognition during this stage (Bruner, 1966; Thompson, 1972).

Learning to use one's affective responses (Licciuti, 1968) and learning to use representational thought (Piaget, 1964) appears to be markedly enhanced and later becomes synomimous with the development of linguistic skills.

Reception. Children who are operating within the preoperational stage tend to focus on parts, centrations, rather than the whole and take considerable time to integrate their perceptions (Elking, 1969; Elking, Doegler, & Go, 1964; Elking & Scott, 1962; Gottschalk, Bryden & Robinovitch, 1964; Teegarden, 1933; Vurpillot, 1969).

Association. Children in the stage of preoperational thought have difficulty developing accurate concepts (Elkind, Van Doornich, & Schwarz, 1967) as they a) may not remember a stimulus (Blank, Weider, & Bridger, 1968), (b) center on molecular parts or centrations, rather than on the molar whole (Abravanel, 1968; Elkind, 1969, p. 20; Ghent, 1961; Goodnow, 1969b, 1972; Pick and Pick, 1966), or (c) are unable to relate one molecular centration to another (Lavrent'eva

& Ruzskaya, 1962). Poor reality testing of concepts, because of the focus on parts leads to relatively unsocialized thought and behavior and to difficulty for the child in understanding fine distinctions between two wholes (Birch & Belmont, 1965).

The most elemental type of association would appear to be the association of two stimuli. A mnemonic (Flavell, 1973) can serve to mediate the two or more stimuli to form the association. During these early associations, the mnemonic used by the facilitator must at least designate a referential event for the child to form the desired association (Rohwer, Key, & Guy, in Rohwer, 1973, p. 34). For more complex associations such as classification (Moely, Olson, Halwes, & Flavel, 1969) or free recall (Rossman, 1970) actual enactment of the referential event directly in the presence of the learner, serves as a better mnemonic. The usefulness of mnemonics has been demonstrated across intellectual ranges, from retardates (Milgram, 1967) to normals, superiors and very superiors (Rohwer, 1966), and across sociocconomic levels (Rohwer, Ammon, Suzuki & Leven, 1971b; Rohwer, Lynch, Leven, & Suzuki, 1968; Rohwer, 1967, Experiment III).

Formation of a concept is by definition an understanding of the stimuli and their association. As the young child has had most experience with visual motor channels, their use in successful concept formation is expected. (In the following section on expression the role of language as a mnemonic is discussed.) Visual and motor manipulation leads to better remembering than only visual manipulation (Zinchenko & Ruzskaya, in Zaporozhets, 1956). Being able to experience the three dimensions of an object, visual-motorically (Denner & Cashden, 1967), or only visually (Werner & Goodnow, 1970), appears to concretize understanding and lead to formation of concepts. Direct manipulation is preferred to visual manipulation for higher order concept formation tasks such as conservation (Minichiello & Goodnow, 1969), or giving descriptions of non standard uses (Goodnow, 1969a). As the concrete operational stage is entered, the advantage of visual and motor over only visual manipulation for concept formation decreases (Goodnow, 1971).

Expression. The ability to form progressively more complex associations appears to developmentally proceed the child's ability to give expression to the association of the same level (Flavell, 1969; Rosner, 1971). Just as a mediator can be used to aid a child forming the association, a mediator can be used to facilitate the child's giving expression to these associations (Flavell, 1969). Mnemonics which have been effectively used with the preoperational stage child include verbal rehearsal (Flavell, Beach, & Clinsky, 1966; Keeney, Cannizzo & Flavell, 1967), iconic rehearsal (Corsini, Pick, & Flavell, 1968) and kinesthetic rehearsal (Posner, 1967). Gestural pointing appears to be too abstract to serve as an effective mnemonic for children at this developmental level (Daehler, Horowitz, Wynne, & Flavel, 1969). The less developmentally mature the child, (a) the less likely he is to use mnemonics spontaneously and continue using the mnemonic strategy when the facilitator ceases prompting (Keeney, Canizzo & Flavell, 1967; Milgram, 1967, 1968b), and (b) the more loudly the child must verbalize for the mnemonics to be successful for him (Flavell, et at., 1966; Kenney et al., 1969).

Because of the relative rudimentary capacity for representational association, a child even in the preoperational stage has difficulty communicating especially when he attempts to communicate fine distinctions (Flavell, 1966). He tends to ascribe much more implied meaning to his words then the listener comprehends (Piaget, 1952b). The child tends to have difficulty distinquishing fact from fantasy, reality from make believe (Moustakas, 1966) and does not realize the impact of his communication on others (Flavell, 1966; Piaget, 1952b).

Language Processing and Head Start

Our role then in Head Start with the preoperational stage child could be one of: (1) aiding the exploration of the child and helping him to perceive systematically using language to reality test his imput.

(2) facilitating association particularly at the representational level, but also at the level of automatic reflex and kinesthetic feedback, relying more on iconic and kinesthetic mnemonic rehearsal during the early stage development and increasing the reliance on verbal mnemonics rehearsal (language) as the child develops during the preoperational stage.

(3) encouraging expression by the child which while at early stage levels are largely non-verbal as the child develops through this stage increasingly acquires concurrent verbal expressions which act as mnemonics both for his forming new associations (concepts) and new responses and response chains in his behavioral expressive repitoire (his ability to systematically recall and use these associations).

Language Learning Disabilities

While environment my help determine the specific language concepts formed, there is only a small significant lag in the ability to perceive in children from "deprived" environments (Elkind, 1969; Elkind & Deblinger, 1969). Our clinical impressions (Gulf Coat Consortium, 1977) have been that children who were referred and later diagnosed as having a language learning disability did not appear:

(1) to have appropriate developmental verbal skill levels, (even in their native language, if other than standard English)

(2) to have a systematic attack plan (use of mnemonics) for receiving, acquiring the associations or for recalling these associations for expression at a later time.

Language development programs would seem to be indicated for these children. Which language program for which children?

Service, Training and Research

To date the Gulf Coast Consortium has focused on service, providing follow-up service to hadicapped children to aid their developmental unfolding. Depending on the background and skills of the provider and the needs of the children, language development programs to remediate language learning disabilities have been the major focus of our handicap consortium.

As models have been developed this year, next year an additional major effort can go into training staff and parents and to researching the effectiveness of each of the service and training models on the amelioration of the language learning disabilities of the child and his family.

BIBLIOGRAPHY

Abravanel, E. The development of intersensory patterning with regard to the selected spatial dimensions. Monographs of the Society for Research in Child Development, 1968, 33, (2 Serial No. 118).

Adkins, P. G. Structured experiences for developmental learning, 1972.

Birch, H. G., & Belmont, L. Auditory-visual integration, intelligence, and reading ability in school children. Perceptual and Motor Skills, 1956, 20, 295-305.

Blank, M., Weider, S. & Bridger, W. Verbal deficiencies in abstract thinking in early reading retardation. American Journal of Orthopsychiatry, 1968, 38, 823-834.

Bruner, J. S. Toward a theory of instruction. Cambridge, Mass.: Harvard University Press, 1966.

Daehler, M. W., Horowitz, A. B., Wynss, F. C. & Flavell, J. H. Verbal and nonverbal rehearsal in children's recall. Child Development, 1969, 40, 443-452.

Denner, B., & Cashden, S. Sensory processing and the recognition of forms in nursery-school children. British Journal of Psychology, 1967, 58, 101-104.

Diebold, A. R. A survey of psycholinguistic research, 1954-1964.' In E. Osgood & A. Sebeok, Psycholinguistics: A survey of theory and research problems. Bloomington: Indiana University Press, 1965.

Donnelly, K. (Ed.) Communicative disorders: learning disabilities. Boston: Little, Brown and Company. In Press, 1977.

Elkind, D. Piagetian and psychometric conceptions of intelligence. Harvard Educational Review, 1969, 319-337.

Elkind, D. & Deblinger, J. Perceptual training and reading achievement in disadvantaged children. Child Development, 1969, 40, 11-19.

Elkind, D., Koegler, R. R., & Go, E. Effects of perceptual training at three age levels. Science, 1962, 137, 3532.

Elkind, D. & Scott, L. Studies in perceptual development I: The decentering of perception. Child Development, 1962, 33, 619-630.

Elkind, D., Van Doorninck, W., & Schwarz, C. Perceptual activity and concept attainment. *Child Development*, 1967, 38, 1153-1161.

Flavell, J. H. *The developmental psychology of Jean Piaget*. Princeton: Van Nostrand, 1963.

Flavell, J. H. Developmental studies of mediated memory. In H. W. Reese & L. P. Lipsitt (Eds.) *Advances in Child Development and Behavior, Vol. 5*, New York: Academic Press, 1970.

Flavell, J. H., Beach, D. H., & Chinsky, J. M. Spontaneous verbal rehearsal in memory task as a function of age. *Child Development*, 1966, 37, 283-299.

Gesell, A. & Thompson, H. *Infant behavior*. New York: McGraw-Hill, 1934.

Ghent, L. Form and its orientation: A child's eye view. *American Journal of Psychology*, 1961, 74, 177-190.

Goodnow, J. J. Effects of active handling, illustrated by uses for objects. *Child Development*, 1969, 40, 201-212. (a)

Goodnow, J. J. Eye and hand: Differential sampling of form and orientation properties. *Neuropychologia*, 1969, 7, 365-373. (b)

Goodnow, J. J. The role of modalities in perceptual and cognitive development. In J. P. Hill (Ed.) *Minnesota Symposia on Child Psychology*. Vol. 5. Minneapolis: The University of Minnesota Press, 1971.

Gottschalk, J., Bryden, M. P., & Rabinovitch, S. Spatial organization of childrens' responses to pictorial display. *Child Development*, 1964, 35, 811-815.

Keeney, T. J., Cannizo, S. R., & Flavell, J. H. Spontaneous and induced verbal rehearsal in a recall task. *Child Development*, 1967, 38, 953-966.

Kirk, S. A. & McCarthy, J. J. The Illinois test of psycholinguistic abilities, an approach to differential diagnosis. *The American Journal of Mental Deficiency*, 1961, 66, 399-412.

Lavrent'eva, T. A., & Ruzskaya, A. G. Comparative analysis of touch and vision: Report V, Simultaneous intersensory comparison of form at a preschool age. *Soviet Psychology and Psychiatry*, 1962, 1, 28-31.

Milgram, N. A. Retention of mediation set in paired-associate learning of normal children and retardates. Journal of Experimental Child Psychology, 1967, 5, 341-349.

Milgram, N. A. The effects of MA and IQ on verbal mediation in paired associate learning. Journal of Genetic Psychology, 1968, 113, 129-143.

Minichiello, M. D., & Goodnow, J. J. Effect of an "action" cue on conservation of amount. Psychonomic Science, 1969, 16, 200-201.

Moely, B. E., Olson, F. A., Haleves, T. G., & Flavell, J. H. Production deficiency in young childrens' clustered recall. Developmental Psychology, 1969, 1, 62-34.

Moustakas, C. E. The authentic teacher: Sensitivity and awareness in the classroom. Cambridge, Mass.: Howard A. Doyle Publishing Co., 1966.

Osgood, C. E. Contemporary approaches to cognition, a behavoristic analysis. Cambridge, Mass.: Harvard University Press, 1957. (a)

Osgood, C. E. Motivational dynamics of language behavior. In M. R. Jones (Ed.), Nebraska Symposium on Motivation. Vol. 5. Lincoln: University of Nebraska Press, 1957. (b)

Osgood, C. E. & Sebeok, T. A., Psycholinguistics: A survey of theory and research problems. Bloomington: Indiana University Press, 1965.

Piaget, J. The origins of intelligence in children. New York: International University Press, 1952. (b)

Piaget, J. Cognitive development in children: the Piaget papers. In R. E. Ripple & V. N. Rockcastle (Eds.) Piaget rediscovered: A report of the conference on cognitive studies and curriculum development. Ithaca: School of Education, Cornell University, March, 1864.

Pick, A. D. & Pick, H. L. Jr. A developmental study of tactual discrimination in blind and sighted children and adults. Psychonomic Science, 1966, 6, 367-368.

Posner, M. I. Characteristics of visual and kinesthetic memory codes. Journal of Experimental Psychology, 1967, 42, 70-77.

Ricciute, H. N. Social and emotional behavior in infancy: Some developmental issues and problems. Merrill-Palmer Quarterly, 1968, 14, 82-100.

Rohwer, W. D., Jr. Constraint, syntax, and meaning in paired-associate learning. Journal of Verbal Learning and Verbal Behavior, 1966, 5, 541-547.

Rosner, S. R. The effects of rehearsal and chunking instructions on childrens' multitrial free recall. Journal of Experimental Child Psychology, 1971, 2 93-105.

Rossman, E. R. Learning from pictures: Performance in a free recall task as a function of age. Unpublished doctoral dissertation, University of California, Berkely, 1970.

Sherman, M. & Sherman, T. C. Sensorimotor responses in infants. Journal of Comparative Psychology, 1925, 5, 53-68.

Teegarden, L. Tests for the tendency to reversal in reading. Journal of Educational Research, 1933, 27, 81-97.

Thompson, W. R. Storage mechanisms in early experience. In A. D. Pick (Ed.) Minnesota Symposium on Child Psychology (Vol. 6). Minneapolis: University of Minnesota Press, 1972.

Vurpillot, E. The development of scanning stratagies and their relation to visual differentiation, Journal of Experimental Child Psychology, 1968, 6, 632-650.

Wawrykow, G. M. Facilitation of learning. A developmental strategy. Unpublished doctoral dissertation. North Texas State University, 1975.

Wawrykow, G. M. Research in early childhood resource development. A research prospectus. Texas Research Institute of Mental Sciences, 1976.

Zaporozhets, A. V. The development of perception in the preschool child. In P. H. Mussen (Ed.), European research in child development, Pp. 82-101. Monographs of the Society for Research in Child Development, 1965, 30, (2 Serial No. 100).

Zubek, J. P. & Solberg, P. A. Human Development. New York: McGraw-Hill, 1954.

FACILITATION OF LEARNING AND MENTAL HEALTH

George M. Wawrykow, Ph.D.
Coordinator of Special Services
Gulf Coast Community Services
Houston, Texas

An earlier version of this paper was presented as part of a panel and workshop entitled "Operational Cooperation: A Replicative Model" At the National Office of Child Development Conference, May, 1977, El Paso, Texas

FACILITATION

of

LEARNING AND MENTAL HEALTH

In clinical practise, it has been found that many patients and clients seek services from a mental hospital or community clinic on a repeated basis known as the "revolving door syndrome". The practices of psychiatry, clinical psychology, and social work have been unable to make substantial significant differences to these people (Carkhuff, 1969a, 1969b, 1971). Some social action programs, such as Head Start, have made some significant differences for many of the children (Lazar, 1977). Hope for families with children who have emotional, behavioral, social or academic problems lies in the children's early learning experiences. Whereas, the clinician has limited contact with a child, the parent and teacher together have continuous contact throughout most of the day.

If these parent-child, teacher-parent, and teacher-child relationships could be enhanced so that they would have a significant and positive impact on the development of the whole child, great strides in both the mental health and educational productivity of the children of our nation could be made.

Head Start, and other early learning experiences can have a marked effect on the developmental unfolding of children. How can this facilitation be assured? What are the variables that make a difference? What can the parent, teacher or significant other do? How can he/she do it to be assured of positive results and facilitation for the child and family? What are the relationships between mental health, the constructive use of affect, and learning? How does the quality and quantity of *facilitation* of learning by significant other(s) relate to acquisition of life skills and successful, mentally healthy living, acquisition of educational skills and successful academic learning, or in acquisition of career skills for successful and fulfilling work?

Our interest concerns the promotion of mental health as well as the facilitation of learning. How the use of affect is basic to learning, growth, and development, particularly of the very young, is the subject of this paper. By using affect systematically, the efficiency for facilitation of learning and mental haelth is increased, leading to cost effective programming.

To the extent that learning experiences contribute to mental haelth, the processes involving the affective, behavioral, and cognitive domains are the media for achieving and/or maintaining mental health. In a developmental strategy for facilitation of learning, the processes of all three domains are integrated. Employment of this strategy should produce not only more efficient learning, but also mentally healthier learners. What are the implications, then, of the developmental strategy for preventing emotional disturbance, learning disabilities, and developmental delays? Initial results in testing the developmental strategy have been dramatic. The general ability of this model to enhance learning and mental health must now be tested. This developmental strategy may provide the next step in a quest for a technology for promoting learning, mental haelth, and for reducing the "revolving door" syndrome in our families.

CURRENT KNOWLEDGE OF EARLY CHILDHOOD DEVELOPMENT

A genotypic, quantifiable and pre-determined capacity for development is inherited. The expression of this capacity follows a developmental sequence (Piaget, 1952b, 1964). How much of this capacity is realized depends largely on the environment. Hunt (1961) has suggested that it is the quality of the match between developmental readiness of the child and the responsiveness of the environment (parent, teacher, or objects) to the child's immediate needs that help learning occur and greater potential to be expressed.

HOME INFLUENCES

Early experiences are important. Young persons who are functionally severely retarded as infants can become productive members of society if intervention is extensive and intensive (Skeels, 1966). Over one-half (½) of a child's intelligence is established by age four (4), and most of it by age seventeen (17) (Bloom, 1964).

The very young child needs something other than academic training in early years (Carew, 1976; Elkind, 1973; Fein, 1975; Weikart et. al., 1970; Weikart, 1972). The needs of the very young child are met through programs empahsizing the human skills for living (Aspy, 1960, 1972, 1973; Carkhuff, 1967, 1972; Elkind & Weiner, 1973; Lamb, 1976). The centrality of these basic life skills is depicted below, (Wawrykow, 1977). Without the core, the sphere may collapse.

Insert Figure I About Here

Programs have been designed to teach parents (Deutch, 1942; Hunt, 1961; Karnes, 1962) to respond to their children at the life skills level.

The normal parent/facilitator is able to respond effectively to the child because he/she has a good relationship with his/her child. If the child does not receive this responsive relationship with a parent or significant other adult, his/her learning growth and development are distorted (Bender, 1953; Despert, 1958; Deutch, 1942; Kanner, 1942; Mahler, 1952; Nyers & Goldforb, 1961; Rank, 1949; Teitze, 1949).

Home educators have successfully taught parents to encourage verbalizations (Karnes, 1968, 1969, 1970). Levenstein (1969, 1970) specified that she taught parents to encourage the child to verbalize a commentary of his on-going activity by modeling a verbal commentary and reinforcing such self-expression in the child. Parents have been systematically taught to respond to many behavioral cues in their children (Cazden, 1972; Cohen, 1977; Krumboltz & Krumboltz, 1973, Wawrykow, 1974).

The quality and the quantity of the parent-child relations are crucially important for the development of the child. The child's relationships with significant others in his early environment are similarly important, and the programs through which these facilitators encourage learning, growth, and development are equally important. Lastly, the means through, and the environment in which the significant other arranges, organizes, and implements the programs will have marked effects (Nimnicht & Johnson, 1973).

SCHOOL INFLUENCES

Just as the interactions and processes resulting from interactions were shown to be of crucial importance in the home, the school interactions and processes are also crucial (Aspy, 1972; Carkhuff, 1971; Coleman, 1966; Hefele, 1970; Plowden, 1966). Besides the child's interactions with his teachers, his interactions with his environment are crucial (Nimnicht & Johnson, 1973). By computer programming a typewriter to give immediate "feedback", very young children were taught to read (Moore & Anderson, 1967). The environment was responsive to the child's immediate goals.

Open informal education is an attempt to organize the environment and the programs within that environment to maximize responsiveness to the learner. This responsiiveness in turn is meant to maximize the impact for learning in the interactions of the child with other persons and with the environment. Open informal education encourages movement from left to right on the following (Coe, 1973; Chittenden, 1973; Hearne, et. al., 1972; McCallan & Wawrykow, 1976; Weber, 1970):

External...................................Internal Control

Punishment and Negative Reinforcers
for Behavioral Control....................Praise and Social Reinforcement
for Behavioral Growth

Other Directed Child
(Responsive Only).........................Child Accepting Direction for Self

External Motivation.......................Internal Motivation

Product Orientation.......................Process Orientation to Learning

Teacher as Source of Facts
and Knowledge.............................Teacher as Facilitator

Curriculum (Same for all).................Individualization and Personalization
of Curriculum

Paper and Pencil Seatwork.................Creative Learning in Activity Centers

It would appear that research up to the present has established that programs for early education can make a difference:

1. Positive (Butler, 1970; Burgess, 1965; Domen, 1964; Durkin, 1966; Moore & Anderson, 1972; Lazar, 1977).

2. Negative (Moore, Moon, and Moore, 1972).

3. Little effect (Kirk, 1969); or the effects can be "washed out" by late elementary school (Circirelli, Westinghouse-Ohio State Report, 1969; Durkin, 1966)

It is possible that each investigator was researching a different intervention or early education approach, meeting with differential success. This does not appear to be the case for Karnes (1968) and Weikart (1970), who, in comparing various approaches, have found positive results. In Weikart's study, using the Bereiter Engleman approach (Engleman, 1967), a traditional nursery school and cognitively oriented pre-school (Kamii, 1972) were compared. Karnes, comparing other approaches, reported similar results. Banta (1967) and Hooper (1972), in comparing Montessori methods with other approaches, found no significant differences. It appears, then, that each approach has something to offer, perhaps something different. It is no longer productive to compare approaches which aim at different objectives when these objectives can be viewed as additive--not mutually exclusive.

By organizing programs to involve the parents, many of the early gains can be maintained (Gordon, 1970, 1972; Smith, 1970). Involvement has taken many forms, including learning to differentially reinforce attitude to an involvement in school work (Smith, 1970), and to parent education programs (Kirk, 1969; Schaefer & Anderson, 1972; Wawrykow, 1974).

In a similar way to home interactions, teacher-child and significant other-child interactions within the school are centrally important.

COMMUNITY

Learning, growth, and development are distorted when the child is unable to perceive his interactions with persons and environment as growth enhancing or facilitative (Bender, 1953; Despert, 1958; Deutch, 1942; Kanner, 1942; Mahler, 1952; Myers & Goldforb, 1961; Rank, 1949; Teitze, 1949). Intervention from the community can make a positive difference (Call, 1963; Klaus & Gray, 1968; Schaefer, 1968, 1972; Schaefer & Anderson, 1973; Gordon, 1969, 1970, 1972) and therapists can teach the child to learn to use facilitation and can teach the parents to facilitate (Wawrykow, 1974). Although cultural differences exist in the quality and quantity of the natural facilitative responses (Nimnicht & Johnson, 1973), persons from any cultural background can learn the procedures (Carkhuff, 1971).

AN HEURISTIC PREDICTIVE EQUATION

Each of these lines of investigation points to the importance of:

1. The interaction between a child and persons of special significance to him.
2. The programs, the means of implementing these interactions.
3. The organization of these programs and person-child interactions.

An heuristic equation for facilitation of early childhood development can now be postulated.

$$\text{Effective Early Childhood Resource Development} = \underbrace{\text{Parent Variables} \quad \text{Parent-Child Variables} \quad \text{Home Contextual Variables} \quad \text{Sibbling Variables}}_{\text{Home}} + \underbrace{\text{Contextual Variables} \quad \text{Program Variables} \quad \text{Teacher Variables} \quad \text{Teaching Process Variables} \quad \text{Pupil Variables}}_{\text{School}} + \underbrace{\text{Significant Other Variables} \quad \text{Cooperative Agency} \quad \text{Cultural Variables}}_{\text{Community}} + \underline{\text{Interaction Variables (persons interacting with school, home, and community variables)}}$$

For home, school, and community, the three variables--people, programs, and organization --are included (Bronfenbrenner, 1974). While the variables have been extensively investigated individually, their interactions have not been subjected to close examination.

Recently, the importance of dealing with the whole child in the context of all of these variables, the child's ecological environment, has been recognized (Bronfenbrenner, 1973a, 1973b, 1974, 1975, 1976; Gump, 1976; Kaplan, Wapner, & Kaplan, 1976; McGurk, 1976; Moos, 1976; Proshansky, 1976; Wapner, 1976). It has been recommended that new research and development projects be considered for their emphasis on the child-ecology system (Hertz, 1976a, 1976b). To what extent can the researcher include all of these variables in his design? To what extent can the teacher or parent fully consider all of these variables, for each interaction with each child, or when planning a program for a group of children? Is there a way to get a "handle" on this system?

FOCUS ON INTERACTIONS

Several processes are involved in the interactions of persons with other persons, programs, and the organization. These interactions can be categorized as the affective, behavioral, and cognitive correlates for facilitation of learning. These *interactions are the interpersonal means of facilitation of intrapersonal processing, and are the basis of learning, growth, and development,* as discussed in the previous paper.

Affective Variables: Carkhuff (1967, 1969, 1971, 1971b), Aspy (1969, 1970, 1972), Berenson (1971), and Hefele (1971) have demonstrated dramatic results for the Human Resource Development (H.R.D.) field theory of learning. They have operationalized the humanistic point of view into researchable components. These components basically included:

1. The interchangeable response for a facilitator to help a child explore and identify specifically where he "is", physically, cognitively, and affectively through systematization of perceptions.

2. The additive statement for helping a child understand where he wants and needs to be through integrating the stimuli perceived in "#1" above.

3. The program development skills for the facilitator to help the child act and express himself.

Behavioral Variables: Skinner (1938, 1953), his associates, and other subsequent researchers such as Whaley (1969) and Martin (1972), have indicated the importance of positive reinforcement for learning and mental health. Children can be facilitated in acquiring self-help skills (Matin, 1972) or academic skills (Krumboltz & Krumboltz, 1973). A ratio of 18.1 of positive reinforcements to aversive stimuli may be optimal for learning in children (Aspy, 1972).

Bandura and Walters (Bandura & Walters, 1964; Bandura, 1969, 1971; Flanders, 1972) have indicated the importance of a potent model for imitation by a child and have shown that modeling can take verbal or non-verbal forms. They have further demonstrated that not only is it important to view another doing a task, but also that the experience of walking through a complex task with guidance is important. Modeling and walking through the task are the major contributions of social learning theory to our knowledge of learning and mental health.

Parkes (1972) has summarized the research on the use of aversive control as it relates to learning and mental health of the young child. An aversive stimulus of the correct intensity and contingency is best used to enforce limits which are broadly set, or to prevent regression. These limits may be interpreted as not hurting others, property, or self. Apparently, little evidence supports the current widespread use of aversive stimuli to control behavior, or as a method of teaching young children.

Cognitive Variables: Jean Piaget (1952b, 1964) and his associates have determined a developmental sequence for cognitive functioning. Before age two (2), a child is only marginally able to picture mental images. He is, in a behavioral sense, stimulus-bound and he reacts accordingly with little evidence of memory traces. From approximately age two (2) to seven (7), the child is able to engage in pre-operational thought. He is unable to use extensive memory for rules and is still very stimulus-bound, but can form mental images. Cazden (1972) and Berenson (1974) suggest that through language, the child learns this mental symbolism.

As discussed in the previous paper, each child must learn to selectively receive input, to understand their relationships to form associations and express himself using the information processed. How can this processing be facilitated?

FACILITATION OF LANGUAGE PROCESSING IN YOUNG CHILDREN

A two phase model for facilitation of learning (Wawrykow, 1975) appears to incorporate the evidence for what aides learning in affective, behavioral, and cognitive areas.

Phase I:

1. Input: The child tries to receive stimuli systematically. The child explores affectively, behaviorally, and cognitively.

   Facilitation of Input: The facilitator aides input by helping the child to perceive selectively the feeling, and the meaning of the feeling for the child. The facilitator gives the child an interchangeable response, or a series of interchangeable responses, to help him perceive where he is, in relation to his environment, the source of all the incoming stimuli.

Insert Figure II About Here

Through this verbalized description, the child symbolizes these stimuli so he/she can continue processing this information internally. The verbalizations must be appropriate in terms of developmental level and cultural connotations, so that he/she can perceive how thses stimuli relate to "where he is" in his environment and so he/she will be able to internalize them.

2. Understanding: The child tries to associate the stimuli, to integrate this symbolized information to understand what he wants or needs (Y) in terms of where he is (X).

Insert Figure III About Here

It is akin to the child taking separate pieces of information and joining them in some relational manner internally. Externally, the child perceives a goal where he wants and needs to be, in terms of where he is. This too, is relational. To teach the child to actively use his/her "associative" process is to teach him initially to label; Later on to develop this process to be used to form concepts; still later, principles. It is essential to problem-solving and learning involving-mediated thought.

The goal which is personalized for each child in each situation provides for the teacher a generalized direction for working with the child.

3. Output: The child expresses himself in terms of, and using, the perceptions and understanding of those perceptions. As a good portion of the information was stored verbally, recall for expression is also largely verbal. As the child becomes older, his expressions become goal-oriented, to get him from "where he is" (X) to "where he wants/needs to be".

Facilitation of Output: The facilitator/parent/teacher will aide the child to use mnemonics to help the child to recall information to help him express himself; to help him formulate and implement programs to get him from "where he is" (X) to "where he wants/needs to be".

Insert Figure IV About Here

4. Staying on Programs: We must help the learner acquire a means of staying on program. That is, what can the facilitator do to ensure that the child will continue processing, once he/she has begun? How can the facilitator help? The child will learn to "stay on program" only if he finds it rewarding. Therefore, we must teach the child to use our reinforcements as rewards. Then, we must teach the child to reinforce himself. The child must learn to verbalize these reinforcements, first aloud; then, quietly; and finally,...internally only. At this point, the child will have acquired internal reinforcement techniques.

Insert Figure V About Here

5. Setting and Maintaining Limits: The facilitator must teach the child to respect people and property by setting and maintaining limits beyond which transgression would be an infringement of others' rights. The child can be taught limit-setting through discussion. He can be taught enforcement of limits through use of aversive control and negative reinforcements. As with positive reinforcement, the facilitator will initially be the source of the verbalized (and non-verbal) negative reinforcement. The object will be to again teach the child to internalize this limit-setting and enforcing behavior.

Insert Figure VI About Here

6. Verbalizing the "Think" and "Do" Steps: The child learns to integrate the program by verbalizing the "think" and "do" steps. The "think" steps come right before, during, and after each "do" step. These "think" steps help the child to get a mental picture of his program.

It is primarily through the verbal symbols or mnemonics that the child can learn to internalize a program. The purpose in internalizing the program is for the child to have it as one response that he can recall from his response repitoire. The object for learning is to :

1. Increase the number of such responses in one's response repitoire.

2. To increase the facility for retrieving these responses.

3. To increase the ability to combine these responses in new ways.

In summary, Phase I involves telling (verbal model), showing (non-verbal model) and doing (walking the child through the program). It involves telling and showing the learner which behavior will be reinforced positively or negatively. It does not involve the traditional didactic presentation. Rather, a participatory experimental exploration, understanding and action process in involved. The telling and showing are mostly implicit, and only to a limited extent explicit and didactic.

Phase II:

In this phase, the child practices exploring his approximations to the program. Learning to master an understanding of how the program can be used, and learning to use it habitually is the substance of this phase.

Insert Figure VIII About Here

To be sure, we give him reinforcements during this phase and teach him to reinforce himself for successive approximations to the most efficient program.

Of course, no parent or teacher will engage in Phase I and II with each child all of the time. This two-phase model simply provides a way of helping a facilitator use all learning theories in an integrated way. The objective would be to teach the child, over time, to explore, understand, and act--to internally use this paradigm in the process of his learning, living, and working.

The developmental strategy gives a means of meeting the child where he is. This is of interest to facilitators of young children, particularly the child development specialists. The strategy also suggests how a facilitator can help a child acquire symbolism or verbal language. The facilitator would use parts of the strategy more often than the full model, as children learn quickly. The most crucial part is helping the facilitator meet the child where he is, for without this match, nothing else matters.

LANGUAGE LEARNING DISABILITIES
DEVELOPMENTAL IMPAIRMENT
and
EMOTIONAL/BEHAVIORAL DISTURBANCE

Within the context of the Developmental Model of Learning, the language learning disabled child is one who has difficulty processing, one who has not learned, or is unable to systematically perceive stimuli, systematically associate stimuli by putting verbal symbols or meaning to these stimuli, and/or is unable to systematically adequately express himself verbally. Such children may not have adequately developed the use of language as a mnemonic for building in the "think" and "do" steps.

If the reason for the lack of development of the language learning skills is organic damage, or an inherited defect, these children will meet the Office of Child Development (O.C.D.) definition of learning disability. This group comprises of 5% of the Head Start population. If the lack of language learning skills is functional, and are due to environment, or lack of verbal learning experiences, the children meet O.C.D. definition of developmental delay (20-30% of H.S. children); Their language processing is defective because of the lack of practice in systematic language (verbal) processing and to the fact that this lack of processing has resulted in a dearth of verbal receptive, associative, or expressive responses. If a child were in an environment in which persons communicated in a telegraphic or non-verbal manner, or if the child, because of some chronic illness, was deprived of learning experiences, the child would be developmentally-delayed. If the reason for the lack of language learning skills was because of the child's inability to use his emotions, but instead, was subject to his emotions, the child would meet O.C.D. classification of emotional disturbance. In fact, the three types of language learning disabilities are inter-related and it is often difficult, if not impossible, to differentiate as to etiology.

Let us look further among the relationships of language processing, language learning disabilities; mental health and emotional disorders. Consider any stimulus about to be received. Each stimulus has both feeling and meaning components. The threshholds beyond which a stimulus can be said to have an affective component varies among "normal" children. Among children who are behaviorally, or emotionally, disturbed, the threshhold varies beyond this range. The child either overlooks the affective component, or over-reacts to the affective component. The E.D. child is unable to receive stimuli accurately, ascribing more or less affect arousal to the stimuli. It follows, then, that associations formed during these mis-focused perceptions are not accurate, nor adequately reality-based. The behavior, based on mis-perception and unreal, or misjudged, associations will then appear erratic and disturbed. The result is a child who is unable to process accurately.

Whether the roots of the language processing difficulties are organic or functional, the net results may be similar. The children will appear to have low receptive, expressive, and memory skills, and will exhibit misjudged or inappropriate behavior. Our goal with each of these groups is to help the children to accurately process information. For the child with receptor or motor damage, or minimal brain injury, the task becomes one of activating alternate centers in the brain. For the child with processing which is overly influenced by distorted affective stimuli, the task also becomes one of restraining the child to process more accurately. For the child with a lack of language processing skills due to lack of language use, the task becomes one of simply establishing linguistic processing responses.

GOAL OF THE HEAD START HANDICAPPED CONSORTIUM

The goal of the Gulf Coast Consortium becomes one of employing consultants to help each program help each child learn to accurately process information. While speech pathologists were able to identify traditional speech problems such as articulation; or voice abnormalities, they also identified many more children with language processing difficulties as having communication disorders. Most children identified by physicians as having developmental delays, similarly had language processing problems. Psychologists tended to place many of these same children into the learning disability category. Therefore, there grew a large body of children, 20-30% of Head Start children, who had language learning disabilities, who could rightfully be given therapy by special education resource persons, speech therapists and/or psychologists. While the means for daily therapy for each of these groups was somewhat different, their ends were similar. The goal of the Gulf Coast Consortium was to get these children the help they needed from whichever source or combination of sources to give each child a true Head Start. Although the terminologies differred, each therapist, regardless of discipline, concentrated on helping the child: (a) process: input, associate, output; (b) use positive and negative reinforcement; and (c) develop and use "think" as well as "do" steps; (d) internalize reinforcement.

RESEARCH EVIDENCE FOR THE DEVELOPMENTAL STRATEGY FOR FACILITATION OF LEARNING, MENTAL HEALTH, AND DEVELOPMENT

With empirical investigation, the 6-point model, outlined in this paper, has been previously found to account for two-thirds (Wawrykow, 1975, p.197; $R^2 = .6615$) of the variance for facilitation of learning. The study, employing this developmental model, was a pioneering effort to research a mix of the combined principles from several different theoretical positions into one integrated *interaction or process model of learning, growth, and development*. Sets of principles were based on human resource development field theory of learning, social learning theory, operant conditioning theory, and aversive control learning theory. Each of 16 treatment conditions represented use of some combination of the sets of principles from the four theories of learning: none at a time, one at a time, two at a time, three at a time, or four at a time--the developmental strategy for facilitation of learning. These sixteen (16) conditions were tested by having specially chosen and trained teachers facilitate learning in five-year-old children, randomly chosen from public school kindergarten. Covariance multilinear regression analyses for a two-attribute model with one-attribute ordered and a five-attribute model with all attributes ordered were employed. The criteria measured the skills of the children to recognize feelings and respond to another in terms of the feeling and meaning recognized. All children were individually pre- and post-tested by the facilitator, while the teaching occurred in groups of six children.

Results with the developmental model were superior (p .0000), on the two criteria measured, to those obtained with all other combinations of learning theories. Considering the developmental stages of the children in this study, processing appeared to be of prime importance for learning. Furthermore, facilitation of learning appeared to be optimized when the facilitator actively engaged the learner in each of the processes: of input-exploration of stimuli, association-understanding of stimuli and their relationships, and output-active expression based on the explorations and associations.

The investigation indicated that affective, behavioral, and cognitive components are important for all learning, but affect was especially important for learning in young children. Facilitators are best able to ascertain where a child is developmentally, affectively, behaviorally, and cognitively through use of the developmental model. Through engaging a child at his particular level, and through personalization of learning for each child, facilitation of the child's learning was maximized. To the extent that affect, behavior, and cognition are involved in any learned response by a child, the use of the developmental model for facilitation of learning would appear to be useful.

If further research similarly supports the usefulness of the tranferable developmental strategy for facilitation of learning, we can look forward to systematization of teacher education, treatment of mental illness, parenting, and systematization of learning itself. The positive results using this model in small groups, indicate that further testing of the model in groups of different sizes, with learners at different stages of development, with different criteria, should be productive.

This investigation supported one strategy for giving the facilitator the flexibility to achieve the optimal mix of the various facilitative skills to foster the most effective learning, growth, and development in children. The challenge is for others to further research and implement this strategy or to formulate a more promising strategy.

LEARNING GROWTH AND DEVELOPMENT

Through constant use of the developmental strategy, we have a direct means of influencing growth and development. To test the long-term effects, the strategy was taught to parents for facilitation of their own children.

Wawrykow (1974) taught parents to respond to their children. Rather than employing the lay notion of global responsiveness, she taught the parents how to specifically respond to where a child was affectively, behaviorally, and cognitively. She did this through teaching the parents the use of the developmental strategy for facilitation of learning (Wawrykow, 1975). By using the strategy, many parents not only were able to respond, but also learned to help their children effectively associate their explorations and to express themselves most effectively in terms of these associations. While Karnes and Levenstein only taught their parents to verbalize for their children, Wawrykow taught the parents what and when to verbalize and how to maximize the process by using a strategy to ensure being accurately "with" their child during the process.

Wawrykow's approach was unique, in that the parents learned in the same manner that they were to use with their children. The program was set up to help the parents process the information experientially. Learning centers of progressive difficulty were arranged to stimulate exploration, understanding and action based on the understanding. Each parent moved to the station appropriate for his/her level (where he/she was) and continued at their own pace. Through this procedure of meeting, each parent knowing where they were, the learning of the use of the strategy for facilitation, was markedly enhanced.

The strategy has also been used: (1) to teach two undergraduate classes in child development, (2) to teach several undergraduate horsemanship classes, and (3) to "school" a horse. The undergraduate sophomores in child development achieved a level of course work proficiency comparable to seniors and masters level students. The horsemanship classes achieved beyond the level of counter-parts taught through normal methods. The horse achieved a level of proficiency in jumping skill and dressage that normally requires two to four years. Thus, there is evidence to indicate that the long term effects of learning through this strategy have influence on growth and development.

In provision of special services within the Gulf Coast Consortium, the convergence of the work of the multi-disciplinary teams, the overall goals and plans for special services, as developed within the Head Start programs, pointed towards and supported the developmental strategy and the relationships between processing, mental health and learning:

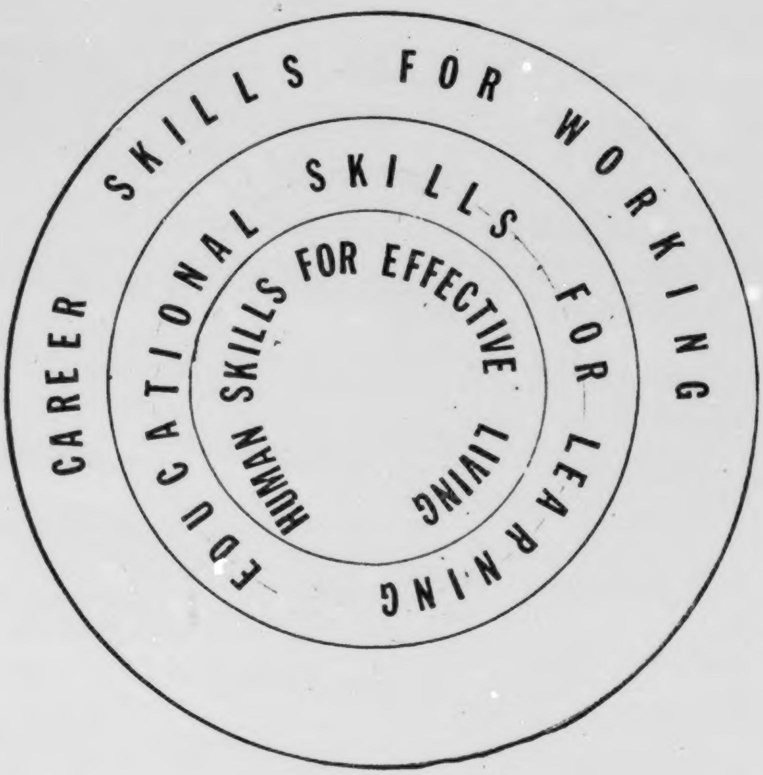
1. The existence of large numbers of children (20-40% of H.S.) that had language learning disabilities.

2. The plans for these children included a majority of the six main points of the developmental strategy discussed in this paper.

3. While individual plans differed somewhat according to the background of consultants (i.e. psychologists tended to work with the children in the classroom; speech therapists tended to adopt a remedial compensatory approach), the goals were very similar.

FIGURE I

CENTRALITY OF HUMAN SKILLS FOR LIVING


CAREER SKILLS FOR WORKING
EDUCATIONAL SKILLS FOR LEARNING
HUMAN SKILLS FOR EFFECTIVE LIVING

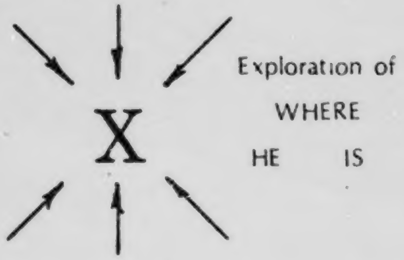
At the core of the sphere of skills acquired during life are the Huamn Skills for Living. Without this central core development, the sphere collapses. Second in importance are the educational skills for learning. Both of these sets of skills are acquired early in life. Our priority with the young child must be the life skills.

FIGURE II

EXPLORATION AND SYSTEMIZING INPUT

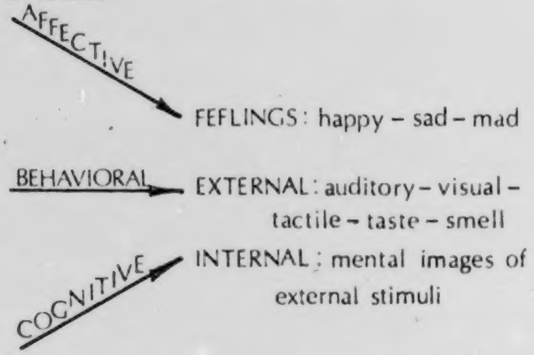
Interpersonal

Child Behavior:


X
Exploration of
WHERE
HE IS

Intrapersonal

Stimuli:


AFFECTIVE
FEELINGS: happy - sad - mad
BEHAVIORAL
EXTERNAL: auditory - visual - tactile - taste - smell
COGNITIVE
INTERNAL: mental images of external stimuli

The child is helped to explore where he is in relation to incoming Affective, Behavioral, and Cognitive Stimuli.

Facilitator Behavior:

Interchangeable Response (IR) to help separate feeling and meaning.

Example #1:

Bonnie: (A 5-year-old child; a new student) she is sitting and looking very sad. For the first half hour of the morning she cries.

Teacher (IR): "You feel scared this morning, because everyone here is a stranger; You don't know anyone and miss your Mommy."

Bonnie: Looking up with tears streaming down her face nods, "Yes!"

Teacher (IR): "You're afraid; the school is new; we are all strangers; you 're scared of us because you don't know us. You are afraid we won't like you."

Bonnie: "Yes."

Example #2:

Andrea: (A 3-year-old in the family life center) puts a doll in a crib tenderly.

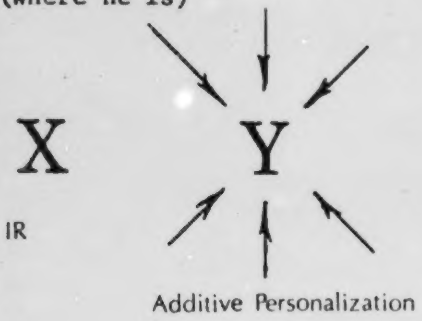
Teacher: "Very nice. You put baby to bed...um-hmmm, covering her up...tucking her in...even a little kiss and hug. You are a loving mother!"

FIGURE III

ASSOCIATION AND UNDERSTANDING RELATIONSHIPS

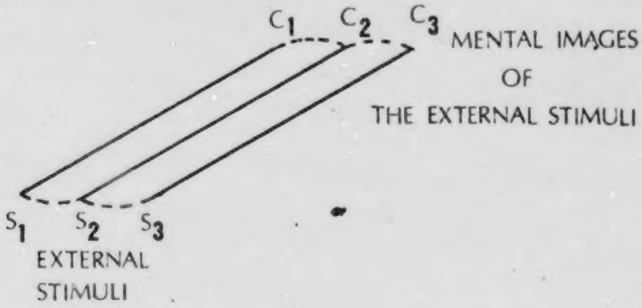
Interpersonal

Child Behavior:
Explore Stimuli
(Where he is)


X
Y
IR
Additive Personalization

Intrapersonal

Understanding Relationships
of One Stimuli to Another
of Where He Is to Where He Wants/Needs To Be


C_1
C_2
C_3
MENTAL IMAGES OF THE EXTERNAL STIMULI
S_1
S_2
S_3
EXTERNAL STIMULI

The child learns to relate one stimulus to another, i.e., to label an object to form a concept...Knives and spoons are eating utensils; or to formulate a goal in terms of where he/she wants to be in terms of where he/she is.

Example #1:

Teacher (AP): (Only after making one or more IR's) "You need for us to love you; you need to know we care, so you'll feel like you matter to us." (Gives child a big hug).

Example #2:

Teacher (IR): "You're taking good care of your baby by doing all those things. (AP) You want to be a good mommy, and you really are."

Example #3:

Teacher: "Tell me what this is...A spoon, right!"

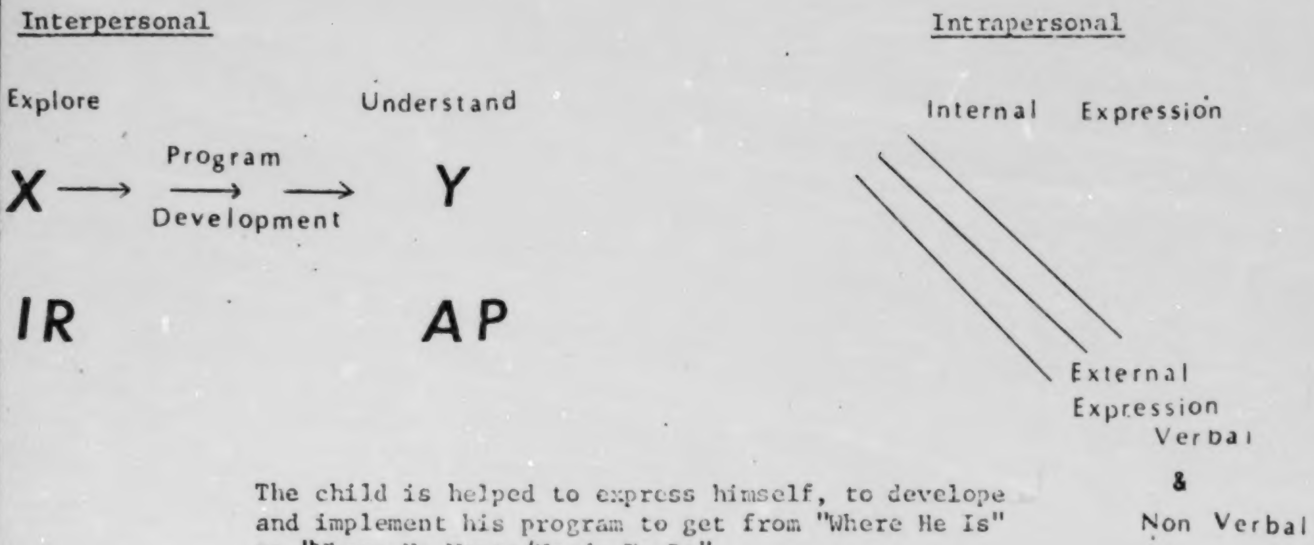
"What is this?...A fork, very good."

"Show me what to do with them!"

"Right, you eat with them...They're all for eating."

FIGURE IV

EXPRESSION


Interpersonal
Explore
Understand
X
Program
Development
Y
IR
AP
Intrapersonal
Internal Expression
External Expression
Verbal
&
Non Verbal

The child is helped to express himself, to develope and implement his program to get from "Where He Is" to "Where He Wants/Needs To Be".

Example #1:

Teacher: (After giving IR and AP) "Come on and meet John, Shirley, and Jan. I know if you begin working hard with these others, you will feel good, too."

Bonnie: "Um-hmmm. I'd like that."

Example #2:

After first verbalizing for the child, now helping the child to verbalize for himself.

Teacher: "Um-hmmm...Good! Tell me about that!"

Andrea: "Me put doll bed."

Teacher: "Right, you put her in bed! Tell me more!"

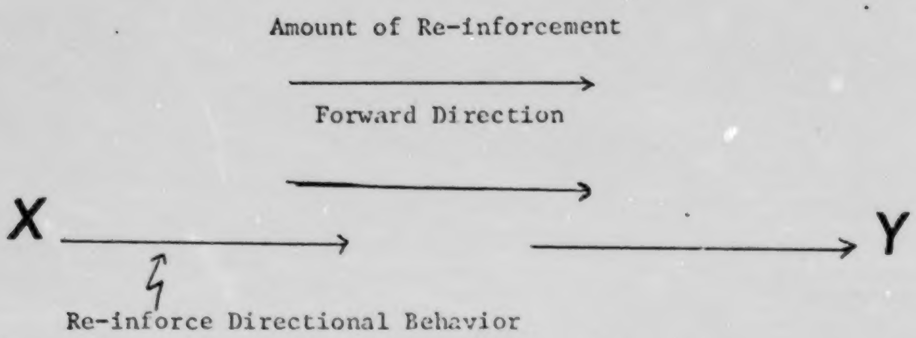
Andrea: "Mommy tell baby story."

Teacher: "Yes, you're a good Mommy; you put baby in bed and now you're going to tell her a story. Please do tell it."

Andrea: "Tell story."

FIGURE V

USE OF RE-INFORCEMENT



The intensity of the re-inforcement will be in proportion to the degree of forward progress in the child's behavior. It must be contiguous, as illustrated, at the same time the child is involved in this behavior.

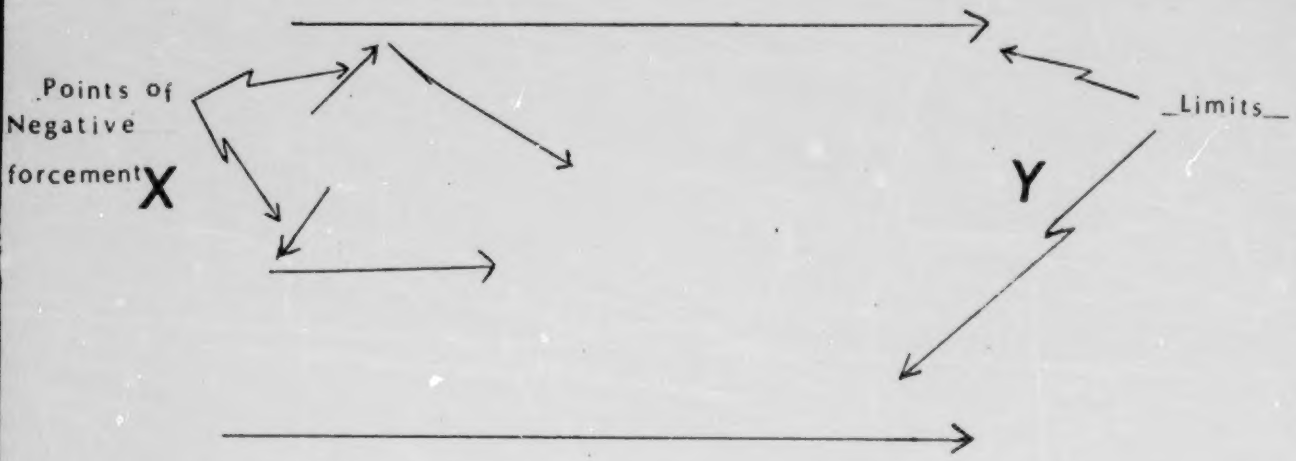
Example #1:

The most explicit example of the use of positive re-inforcement is the game "Warmer, Warmer". In this game, the leader chooses a spot somewhere in the room. This children name objects they think might be the leader's chosen object. The leader replies "warm", if the child's choice is in close proximity to the leader's chosen object; he replies "cold" if it is not. The leader replies "warmer" as the chosen object is neared or "colder" if the child's choice is in the opposite direction. When the children's choices come progressively close, the leader replies "hot, hotter, very hot, boiling", etc. The main point of consideration is that re-inforcement is in proportion to the degree of goal-oriented progress. The facilitator can teach the child by his example and then to internally give himself this re-inforcement.

In the above example, the warm to hot replies are examples of positive re-inforcement; the cool to cold replies are examples of negative re-inforcement which is discussed under point #5.

FIGURE VI

LIMIT SETTING AND ENFORCEMENT



The aversive stimulus must be only severe enough to prevent transgression of the limits. The limits prevent the child from hurting others (infringing on their rights) or damaging property. An aversive stimulus can also be used to prevent the child from regressing or hurting himself in any way.

The aversive stimulus must be only amply severe to prevent trangression of limits or regression. If it is too strong, it may cause behavior resulting from an emotional reaction; a reaction we may not be able to handle, and one that results in even more undesirable or limit-breaking behavior. If too weak, the child may simply become desensitized to aversive control and acquire a higher thresh-hold for aversive stimuli.

An example of prevention of transgression in the "warmer, warmer" game would be a response to the child, choosing an object outside of the classroom.

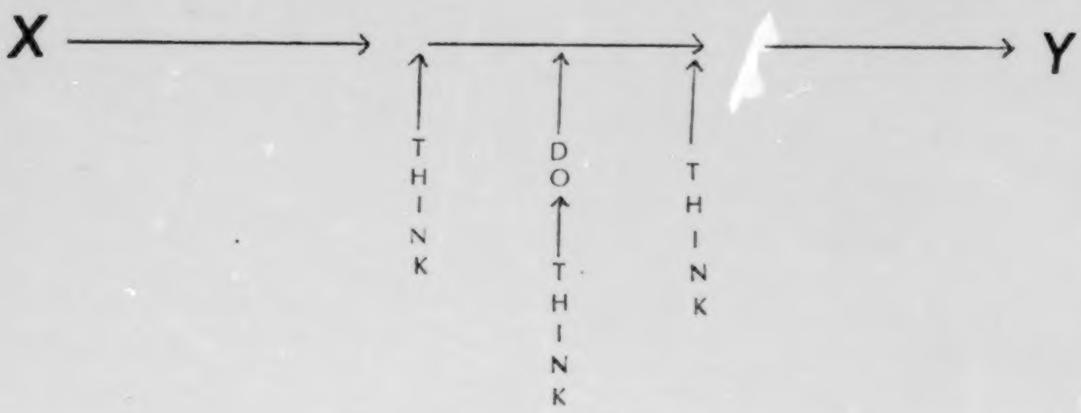
Teacher: "No, the fire hydrant is not in our room. You must choose from objects within this room."

An example of prevention of regression in this same game would be telling the child his choice was in the opposite direction from the object and that area had been already covered.

FIGURE VII

INTEGRATING THE RESPONSE PROGRAM

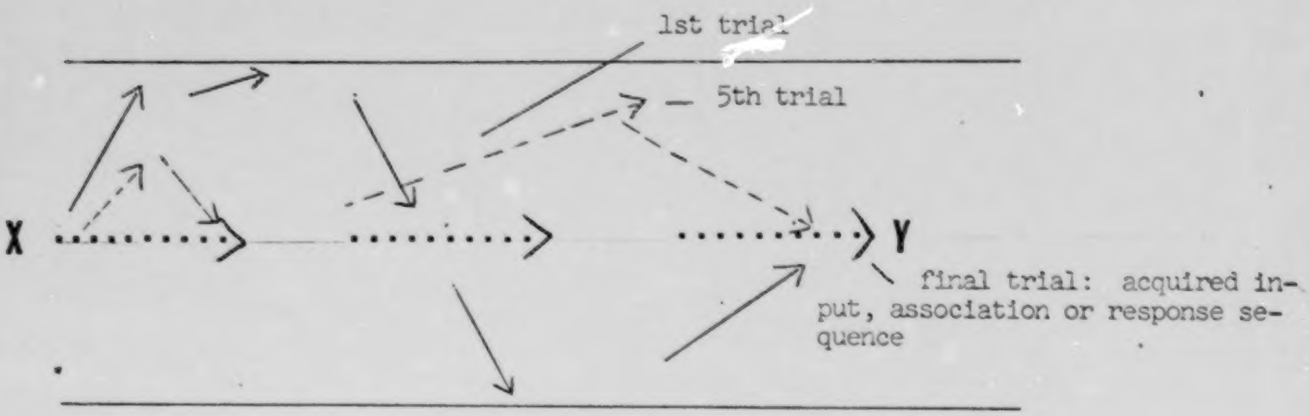
Verbalizing "think" and "do" Steps



Through the verbal symbols of language, before, during and after each physically performed, overt step of a program, the covert steps can be rehearsed. Rehearsal of the covert and overt together helps the child remember the program response for future retrieval.

FIGURE VIII

CHAINING RESPONSES TO FORM A PROGRAM FOR LATER RECALL & USE


1st trial
5th trial
X
Y
final trial: acquired input, association or response sequence

In this phase, the child practices exploring his approximations to the program. Learning to master an understanding of how the program can be used, and learning to use it habitually is the substance of this phase.

BIBLIOGRAPHY

Aspy, D.N. The effects of teacher offered conditions of empathy, positive regard, and congruence, upon student achievement. *Florida Journal of Education*, 1969, 11, 39-48.

Aspy, D.N. The relationship of the trainer's level of interpersonal functioning and change in teacher behavior. *Educational Leadership Research Supplement*, 1971, 28.

Aspy, D.N. Better self-concepts through success. *Journal of Negro Education*, 1971, *40*, 369-372.

Aspy, D.N. *Toward a technology for humanizing education*. Champaign, Illin.: Research Press, 1972.

Aspy, D.N. *A practical psychology for practical educators*. Dallas: National Consortium for Education, 1973.

Aspy, D.N. & Roebuck, F.N. *The National Consortium for Humanizing Education: A three year report*. Munroe, Louisiana: Northeast Louisiana University, 1975.

Bandura, A. *Principles of behavior modification*. New York: Holt, 1969.

Bandura, A. *Psychological modeling: Conflict theories*. New York: Lieber-Atherton, 1971.

Bandura, A. & Walters, R.H. *Social Learning and personality development*. New York: Holt, Rinehart, & Winston, 1963.

Banta, T.J. The Montessori research project: Project report (mimeo). Cincinnati: University of Cincinnati, 1967.

Bender, L. Childhood schizophrenia. *Psychiatric Quarterly*, 1953, *27*, 663-681.

Berenson, D.H. The effects of systematic human relations training upon classroom performance of elementary school teachers. *Journal of Research and Development in Education*, 1971, *4*, 70-85.

Berenson, D. Teaching. Workshop presentation at the Human Resource Development Institute, Amherst, Massachusetts, November, 1972.

Bloom, B.S. *Stability and change in human characteristics*. New York: John Wiley & Sons, 1964.

Brim, O.G. Macro-structural influence on child development and the need for childhood social indicators. *American Journal of Orthopsychiatry*, 1975, *45*, 516-524.

Bronfenbrenner, U. A theoretical perspective for research in human development. In H.P. Dreitzel (Ed.) *Childhood and socialization: Recent Sociology*, No. 5. New York: Collier: Macmillan, 1973(a).

Bronfenbrenner, U. Social ecology of human development. In F. Richardson (Ed.) *Brain and intelligence: The ecology of child development*. Hyattsville, Md.: The National Education Press, 1973(b).

Bronfenbrenner, U. Developmental research, public policy, and the ecology of childhood. *Child Development*, 1974, 45, 1-5.

Bronfenbrenner, U. Is early intervention effective? A report on longitudinal evaluations of pre-school programs (Vol. 2). Washington, D.C.: Department of H.E.W., Office of Child Development, 1974.

Bronfenbrenner, U. *The experimental ecology of human development*. Paper presented at the Annual Meeting of the American Psychological Association, 1975.

Bronfenbrenner, U. *The Experimental ecology of education*. *The Educational Researcher*, 1976, *5*, 5-15.

Burgess, E. *Values in early childhood education*. Washington, D.C.: EKNE National Education Association, 1965.

Call, J.D. Prevention of autism in a young infant in a well-child conference. Journal of the American Academy of Child Psychiatry, 1963, *2*, 451-459.

Carew, Jean V. Effective home learning environments in the pre-school years. In *Update: The first ten years of life*. M.L. Hanes, I.J. Gordon, & W.B. Breivogel, (Eds.) Gainesville, Florida: Division of Continuing Education, University of Florida, 1976.

Carkhuff, R.R. *Helping and Human relations: A primer for lay and professional helpers. Vol. I. Selection and training*. New York: Holt, Rinehart, & Winston, 1969.

Carkhuff, R.R. *Helping and Human relations: A primer for lay and professional helpers. Vol. II. Practice and research*. New York: Holt, Rinehart, & Winston, 1969.

Carkhuff, R.R. *The development of human resources: Education, psychology, and social change*. New York: Holt, Rinehart, & Winston, 1971.

Carkhuff, R.R. Principles of social action in training for new careers in human services. *Journal of Counseling Psychology*, 1971, 18, 147-151.

Carkhuff, R.R. Belly-to-belly and back-to-back: Toward a humanistic technology for the family of man. Counseling and Values, 1972, 16, 169-174.

Cazden, C.B. *Child language and education*. New York: Holt, Rinehart, & Winston, 1972.

Chittenden, E. Research and assessment strategies. Chapter in Hearne, H.H.; Burdin, J.K.; Datz, L.; *Current research and perspectives in open education*. Washington: American Association for Elementary-Kindergarten-Nursery Educators, 1973.

Cole, M.; Frankel, F.; and Sharp, D. Development of free recall learning in children. *Developmental Psychology*, 1971, *4*, 109-123.

Cicirelli, V.G. The impact of Head Start: An evaluation of the effects of Head Start on children's cognitive and affective development. Washington, D.C.: Westinghouse Learning Corporation and Ohio University (OEO contract B89-4536), 1969.

Despert, J.L. Some considerations relating to the genesis of autistic behavior in children. *American Journal of Orthopsychiatry*, 1951, *21*, 335-350.

Deutsch, H. Some forms of emotional disturbance and their relationships to schizophrnia.

Psychoanalytic Quarterly, 1942, *11*, 301-321..

Domen, G. *How to teach your baby to read*. New York: Random, 1964.

Durkin, D. *Children who read early*. New York: Teachers College Press, 1966.

Elkind, D. & Weiner, J.B. *Child development: A core approach*. New York: Wiley & Sons, 1972.

Engleman, S. & Engleman, T. *Preventing failure in the primary grades*. New York: Simon and Shuster, 1969.

Fein, G.G. Children's sensitivity to social contexts at age 18 months of age. *Developmental Psychology*, 1975.

Gordon, I.J. The beginnings of the self: the problems of the nurturing environment. *Phi Delta Kappan,* March, 1969, 375-378.

Gordon, I.J. The Florida parent education program. Paper of the Institute for Development of Human Resources, College of Education, University of Florida, Gainesville, 1970.

Gordon, I.J. (Ed.) *Early childhood education: 71st Yearbook of the National Society for the Study of Education, Part II*. NSSE. Chicago: The University of Chicago Press, 1972.

Gump, P.V. Ecological psychology and children. In E.M. Hetherington (Ed.) *Review of Child Development Research*. Chicago: University of Chicago Press, 1976.

Hearne, D.D., Burdin, J.K., Katz, L. Current research and perspectives in open education. Washington: American Association for Elementary-Kindergarten-Nursery Educators, 1973.

Hefele, T.J. The effects of systematic human relations training upon student achievement. *Journal of Research and Development in Education*, 1971, *4*, 52-69.

Hertz, T.W. (Ed.) Proceedings of the symposium on ecological approaches to research on child development. Sponsored by the Interagency Panel on Early Childhood Research and Development. September, 1976.

Hertz, T.W. The ecology of child development: Research issues--the child/the family/the environment/services. A report for planners of research and development. Prepared for the Interagency Panel on Early Childhood Research and Development. Social Research Group, George Washington University, Washington, D.C., 1976.

Hooper, F.H. An evaluation of logical operations instruction in the pre-school. Chapter 5 in Parker, R.K. *The pre-school in action: Exploring early childhood programs*. Boston: Allyn and Bacon, Inc., 1972.

Hunt, J. McV. *Intelligence and experience*. New York: Ronald Press, 1961.

Jensen, A.R. How much can we boost IQ and scholastic achievement? *Harvard Educational Review*, 1969, 39, 1-123.

Kamii, C. An application of Piaget's theory to conceptualization of a pre-school curriculum. In R.K. Parker (Ed.), *The pre-school in action: Exploring early childhood programs*. Boston: Allyn & Bacon, Inc., 1972.

Kanner, I. Autistic disturbances of affective contact. *Journal of Nervousness in childhood*, 1942, *2*, 217-250.

Kaplan, B., Wapner, S. & Cohen, S.B. Exploratory applications of the organismic--developmental approach to man-in-environment transactions. In Wapner, S., Cohen, S.B., & Kaplan, B. (Eds.) *Experiencing the environment*. New York: Plenum Press, 1976.

Karnes, M.B. A new role for teachers: Involving the entire family in the education of pre-school disadvantaged children. Project Report. Institute for Research on Exceptional Children, College of Education, University of Illinois, Urbana, Illinois, 1969.

Karnes, M.B., Teska, J.A., Hodgins, A.S., & Badger, E.D. *Child Development*, 1970, *41*, 925-935.

Kirk, S.A. The effects of early education with disadvantaged infants. In Karnes, M.B., Research and development program on pre-school disadvantaged children, Vol. I OE6-10-235, No. 5-1181. Final Report, May, 1969, p. 233-248.

Klaus, R.A. & Gray, S.W. The early training project for disadvantaged children: A report after five years. *Monograph of the Society for Research in Child Development*, 1968, *33*, 4.

Krumboltz, J.D. & Krumboltz, H.B. Changing children's behavior. Englewood Cliffs, New Jersey: Prentice-Hall, 1972.

Lamb, M.E. Interactions between eight-months-olds and their fathers and mothers. In Lamb, M.E. (Ed.) *The role of the father in child development*. New York: Wiley, 1976.

Lazar, I. Sessions leader. Longitudinal data in child development programs. (I., II.) Panel Sessions at the Office of Child Development Conference: Parents, Children and Continuity, El Paso, May, 1977.

Levenstein, P. Individual variation among pre-schoolers in a cognitive intervention program in low-income families. Presented at the Conference on Early Childhood Education. Council for Exceptional Children, Freeport, New York, December, 1969.

Levenstein, P. Cognitive growth in pre-schoolers through verbal interaction with mothers. American Journal of Orthopsychiatry, 1970, 40.

Mahler, M.S. On child psychosis and schizophrenia, autistic and symbiotic infantile psychosis. *The Psychoanalytic Study of the Child*, 1952, *7*, 286-305.

Martin, C.Q. Educational programs for children under six with implications for the handicapped. *The Distinguished Staff Training Monograph Series*, 1972, *1*, 1.

McGurk, H. (Ed.) *Ecological factors in human development*. Amsterdam: North Holland, 1976.

Meyers, D.I. & Coldfarb, W. Studies in perplexity in mothers of schizophrenic children. *American Journal of Orthopsychiatry*, 1961, *31*, 551-564.

Moore, R.S., Moon, R.D., Moore, D.R. The California Report: Early schooling for all? *Phi Delta Kappan,* Summer, 1972.

Moore, O.K. & Anderson, A.R. The responsive environment project. Chapter in Hess, R.D. & Bear, R.M. *Early Education*. Chicago: Aldine Publishing Co., 1967.

Moos, R.H. *The human context: Environmental determinants of behavior*. New York: Wiley-Interscience, 1976.

Nimnicht, G.P. & Johnson, J.A. Jr. (Eds.) *Beyond "Compensatory Education": A new approach to educating children*. San Francisco: Far Western Laboratory for Educational Research and Development, Federal Document, 1973.

Parke, R.D., Ewall, W., & Slaby, R.G. Hostile and helpful verbalizations as regulators of nonverbal aggression. *Journal of Personality and Social Psychology*, 1972, 23, 243-248.

Piaget, J. *The origins of intelligence in children*. New York: International University Press, 1952.

Piaget, J. Cognitive development in children: the Piaget papers. In Ripple, R.E. & Rockcastle, V.N. (Eds.), *Piaget rediscovered: A report of the conference on cognitive studies and curriculum development*. Ithaca: School of Education, Cornell University, March, 1964

Plowden, Lady (Chairperson) *Plowden report: Informal school in Brittain today*. New York: Citation Press, 1967.

Proshansky, H.M. Environmental psychology and the real world. *American Psychologist*, 1976, *31*, 303-310.

Rank, B. Adaptation of the psychoanalytic technique for the treatment of young children with atypical development. *American Journal of Orthopsychiatry*, 1949, 19, 130-139.

Renz, L. & Cohen, M. Interpersonal skill practice as a component in effective parent training. *Community Mental Health Journal*, 1977, *13*, 1, 54-57.

Rogers, D. *Child Psychology*. Belmont, California: Brooks/Cole, 1969.

Schaefer, E.S. A home tutoring program. *Children*, 1969, 16, 59-61.

Schaefer, E.S. Parents as educators: Evidence from cross sectional, longitudinal and intervention research. *The Young Child: Reviews of Research, Vol. II.* Washington, D.C.: National Association for the Education of Young Children, 1972.

Schaefer, E.S. & Aaronson, M. Infant education research project: Implementation and implications of a home tutoring program. In Parker, R.R., *The pre-school in action: Exploring early childhood programs*. Boston: Allyn and Bacon, 1972.

Sears, R. Your ancients revisited: A history of child development. In Heatherington, M. (Ed.) *Review of Child Development Research, Vol. 5.* Chicago: University of Chicago Press, 1975.

Senn, M.J.E. Insight on the child development movement in the United States. Monographs of the Society for Research in Child Development, 1975, *40*, (3-4, Serial No. 161).

Skeels, H.M. Adult status of children with contrasting early life experiences. *Monographs of the society for research in child development*, 1966, *31*, 3.

Skinner, B.F. The behavior of organisms: An experimental analysis. New York: Appleton-Century-Crofts, 1938.

Skinner, B.F. Science and human behavior. New York: Macmillan, 1953.

Skinner, B.F. The experimental analysis of behavior. American Scientist, 1957, 45, 343-371.

Tietze, T. A study of mothers of schizophrenic patients. Psychiatry, 1949, 12, 55-65.

Van Allen, R. Reading programs: Alternatives for improvement. Elementary-Kindergarten-Nursery Educators, 1973, Washington.

Wapner, S., Cohen, S.B., and Kaplan, B. (Eds.) Experiencing the Environment. New York: Plennum Press, 1976.

Wawrykow, G.M. Toward an effective early childhood resource development. For pre-schoolers, their teachers, associates, aides, and parents. Manuscript in preparation, 1978.

Wawrykow, G.M. The effects of a teacher's employing principles from four models of learning, singularly and in combination upon the acquisition of the skill responding to feeling in five-year-olds in kindergarten. Doctoral dissertation, North Texas State University, 1975.

Wawrykow, G.M. Facilitation of human learning: A developmental strategy. Book submitted for publication, 1978.

Wawrykow, L.A. The effects of a parent program focused upon enhancing social-emotional development of young children through parent instruction in affective-interpersonal facilitation. Unpublished Masters Thesis. North Texas State University, December, 1974.

Weikert, D.P. Longitudinal results of the Ypsilianti Perry pre-school project. 1972. Ypsilanti, Mich,: High/Scope Educational Research Foundation.

Weikart, D., Deloria, D., Lawse[illegible], S., Weigerink, R. Longitudinal results of the Ypsalanti Perry pre-school project. Office of Education, H.E.W., Washington, 1970.

Whaley, D.L. & Malott, R.W. Elementary principles of behavior. New York: Appleton-Century-Crofts, 1971.

MENTAL HEALTH

Presented at OCD Conference, El Paso, Texas, May, 1977

A Replicable Model for Immediate Intervention on Behalf of Handicapped Children

Panel Participants: Mary Cay Welsh, Ph.D., George Wawrykow, Ph.D.,
Cynthia Almaraz, Zadie Bergeron, Colleen Christie,
Debbie Fisher, Judy Matherne

We began this psychological services project with four head start centers with two major needs to be met. First, from the head start centers there existed a need to acquire professional psychological services relatively inexpensively, and secondly, our community psychology program needed a children's facility where graduate students could gain experience working with children in a natural setting and where they could become aware of the problems and needs of teachers and others dealing with youngsters.

Previous studies have indicated that a high proportion of children from disadvantaged families (generally at least 50%) exhibit a high rate of emotional disturbance and developmental difficulties, yet the traditional clinical model of psychology does not lend itself to dealing effectively with this group of individuals. In the traditional model a client (or his family) brings himself into the office of the professional. Thus, 1) the difficulty must exist to the extent that it is defined as a problem, 2) the individual must determine to which professional he should go to seek help, and 3) the professional must be relatively accessible in location, time and cost. All too frequently, however, it is impossible for this group of individuals who are in great need of intervention to seek professional treatment. The working or lower class parent is likely not to be aware of many of the behaviors of a child that the general s[illegible] and the school environment in which the child must later function define as deviant. Further, previous studies have indicated that these parents are somewhat distrustful of mental health professionals and are not likely to readily seek their services.

Beyond these problems, the traditional clinical psychology model of therapy is ill suited to the needs of the young, lower class child. For these youngsters, the skills that they need within their social milieu are not readily apparent from individual play therapy sessions. Emphasis needs to be placed on the child's present environment (not his recollections) and a major function of therapy should be to teach the child to deal directly with his environment and manipulate it effectively. Due to the magnitude of handicapping conditions within this group of children, we decided to provide consultative and direct services within the head start setting. The program was implemented to accomplish the following goals:

(1) To provide screening and psychological assessments on children as quickly as possible in order to determine the nature and extent of disorders.

(2) To begin implementation of remedial procedures concurrently with the diagnostic procedures.

(3) To evaluate the needs of the child within the head start environment.

(4) To act as a consultant to those teachers and teachers aides within the center with whom the child spends a large proportion of his day.

Before beginning this sort of program, however, a number of factors unique to the centers had to be considered. First, no consultative program regardless of its professional expertise can be successful without the trust and support of the directors, teachers, aides and other professional staff. Previous programs consulting to schools have frequently reported that teachers were uncooperative ause th elt threatened by psychologists who might be "psychoanalyzing" them or who might be critical of their performance as teachers and might reflect on their job evaluations. Other programs have experienced difficulty because teachers did not feel that the psychologists understood the real problems they faced in the classroom and thus focused on areas that were not seen as relevant or the recommendations of the psychologist were unclear of impossible to carry out in the class setting.

We spent a great deal of effort initially in establishing rapport and communication with the staff in the various centers. This was aided by the endorsement and enthusiam of the project coordinator, particularly in gaining the support of the center directors. These individuals were then active in encouraging the teachers and aides to approach the psychological consultants for referrals as well as for general exchanges of information. With this groundwork laid we could then begin to ascertain the psychological needs of the centers.

The four head start centers differed greatly on many variables. The cultural, racial and socio-economic factors were varied.(3 of the centers were predominately Black, 1 was predominately American Indian, some centers consisted of children of parents who had low incomes, but were employed, while others came from more impoverished unemployed families). The physical facilities and size of the programs varied from small community center or church programs to a large (125) school related program. Teachers varied in training experience from certified classroom teachers to those without high school diplomas. Some programs were half day programs while others were full day programs.

In order to establish a good understanding of the psychological needs that existed within each program, the graduate students initially spent several days a week at the centers. They spent this initial period primarily engaged in testing children who during previous screening procedures were identified as having possible learning or developmental problems or who in the opinions of the teachers needed formal assessment. All of these evaluations took place after the children had been screened for medical problems as well as auditory difficulties. Again, due to differing factors at the various centers, there was some variability in the number of psychologicals requested and thus performed. At the Indian Reservation center, 13 children of 35 enrolled were evaluated, at Van Buckner 10 of 35 were evaluated, at Pipkin 8 of 40 were evaluated and at Carver 11 of 120 were evaluated. The high test referral rate at the Indian Reservation can be attributed to at least two major factors. First, the children had earlier received a screening consisting of the Peabody Picture Vocabulary Test and thus the teachers already had professional recommendations on these children that they be further evaluated. Secondly, these Indian children were generally bilingual (some trilingual) and their English language skills were somewhat deficient, therefore, teachers were unsure as to whether their classroom difficulties were attributable to these language and cultural factors or some other disorder. As a point of interest, those Indian children who were tested yielded a relatively consistent and unusual scatter on the WPPSI. They typically scored markedly higher than average on the performance scale (around 120) while scoring low on the verbal scale (80). Thus, the full scale scores generally fell within the average range of intelligence, but with notably different strengths and weaknesses from that expected in the average middle class Anglo child.

The low rate of referrals for testing from the Carver program is probably attributable to the fact that that center was affiliated with a regular elementary school and contained more certified teachers. These teachers were accustomed to working with psychologists and were more familiar with the kind of difficulties that psychological testing could and could not pinpoint.

Overall, the response from the teachers was favorable concerning the psychological reports. This is in contrast to some programs which have reported teacher dissatisfaction with psychological reports on the basis that they were too vague or that the recommendations were impossible to implement. In our program, remedial procedures were initiated as soon as evaluations and classroom observations had been conducted. Thus, the graduate student could define his recommendations according to the conditions of the classroom and could implement them for the teacher to observe. By the time that the formal report arrived (generally 2 - 3 weeks later), the teacher could incorporate the techniques and procedures used with the findings and recommendations of the report. Teachers began to feel less threatened by the psychological evaluations and were more confident in their own abilities to deal with difficulties in the children. In reporting on her evaluation of the testing one head teacher wrote: "One of the most important facets of the overall "handicapped" program, in my opinion, has been the general assistance with assessing the head start students. Many of the diagnoses were ones that I had expected, many others were enlightening. Practically all of them were valid after I had examined the children and the specific areas more carefully."

To us this indicates that an effective interchange has occurred. In the future, we anticipate fewer requests for formal evaluations since the teachers are now more confident in their abilities to identify educational and behavioral difficulties in the classroom without relying on psychologicals. Thus, remediation can begin in many cases without extensive (and expensive) formal testing.

An important contribution to the understanding of the child's difficulties was gained by observing the youngster in the classroom setting. In this way, the child's relations with his peers and teachers could be assessed. His behavior in various situations could be noted, including: 1) how and to what kinds of reinforcers he responded; 2) what kinds of situations elicited frustration;

3) his reaction to frustration, etc. The children easily became accustomed to the graduate students' presence and rapport was easily established by working with the children in small groups. The children were then less threatened when invited to go to a different room for individual evaluation. Again, this kind of opportunity is not generally available in a traditional clinical model.

After initial testing and observations had been completed, treatment programs were initiated. These varied from center to center based on the problems delineated and the facilities available. Primary deficits could be roughly categorized as language/communication disorders or behavioral problems such as short attention span, poor impulse control and inappropriate interpersonal skills. (This was generally over aggressiveness with peers.)

The children who had difficulty in verbal expression were seen individually and in small groups of 4 or 5 for 20 - 30 minute sessions. The therapists read or told stories and began shaping the children's verbal responses to the stories. The children were asked to explain what was happening, what the characters felt, etc. For those children who also exhibited problems with verbal concept formation, games and exercises dealing with colors, numbers and other concepts were emphasized. Frequently these children had had difficulty communicating due to the lack of an understanding of a verbal label attached to a concept.

With more problematic children individual sessions were designed for specific deficits. Some children revealed minimal verbalizations and an array of developmental deficits. An individualized program was begun utilizing shaping and reinforcement of verbalizations as well as teaching of basic color naming and counting skills. Other children exhibited some emotional disturbances and were seen individually in play therapy that focused on identifying and dealing with feelings.

Along with the major aims of the therapy programs it was believed that procedures which would increase attention to materials would be beneficial and a general increase in self-esteem would enhance learning skills. Therefore, the following techniques or principles were generally utilized:

New materials were presented initially in relatively small chunks with which the child could be successful. With increasing numbers of success experiences difficulty and length of attention required were increased without the child feeling overwhelmed. With increasing proficiency secondary reinforcers or cues were initiated so that the child could learn to delay gratification. These varied from beads on a string to gold stars which when accumulated resulted in a desired consequence. Reinforcers were somewhat individualized and based on the children or the facilities. Commonly used ones were 1) opportunity to go to play room, 2) to use soap bubbles, 3) balloons, etc.

For children with behavior problems additional procedures such as brief time-outs from the group or play activities were used. Some specific behavior problems were dealt with by teaching the children to raise their hand before talking or to ask permission before leaving the room.

In all, 58 children were worked with individually and/or in groups. At the onset of the program, teachers were asked to rate these children on a behavior rating scale. At the end of the semester these measures were again taken. The evaluations indicated that the teachers did observe considerable change in the children's behavior. It may be that these changes are due to a number of factors. First, the teachers who were also working with the children did have some investment in seeing improvements; secondly, the children were receiving increased attention and exposure to new activities; third, many of the pupils identified as "handicapped" by psychology were being seen in therapy by speech and hearing graduate students. It is nonetheless important that the teachers did perceive positive changes. This is likely to lead to increased confidence and self-esteem for them which should be reflected in a beneficial atmosphere in the classroom.

The teachers are more willing to initiate new procedures and ask for consultation since improvements have been accomplished.

Although our program has been brief, we feel that important gains have been made and that we can begin evolving to a better program. By necessity we spent a great deal of time establishing communication and trust within the centers and in determining the needs within the centers. A preconceived notion of the difficulties would have led to resentment from teachers and would have ignored the unique conditions existing within each center. Now that these have been determined more specific goals (relevant to each center) can be delineated and thus we can more accurately evaluate our program.

More in-service training sessions are to be scheduled to increase continuity between the other direct service providers such as speech and hearing. In service training to teachers would allow the graduate students to move towards more of a consultative role rather than a direct service provider. Thus, teachers could begin utilizing our techniques in the absence of the psychology students.

Involvement with parents should be encouraged. Although this was attempted, little success was gained. For example, all parents signed release forms to allow their children to be psychologically evaluated and were informed of the day that this would occur. Letters were also sent out indicating when the examiners would be available to talk with the parents for a feedback interview. Only two parents responded.

Staffing of children with multiple handicaps should emphasize a team approach with treatment goals and plans of speech and hearing and psychology and the classroom teacher closely coordinated to insure continuity.

References

Golann, S.E., & Eisdorfer, C. (Eds.). Handbook of Community Mental Health. New York: Appleton-Century-Crofts, 1972.

Guerney, B.G., Jr. (Ed.). Psychotherapeutic Agents: New Roles for Nonprofessionals, Parents, and Teachers. New York: Holt, Rinehart, & Winston, Inc., 1969.

Lamb, H.R., Heath, D., & Downing, J.J. (Eds.) Handbook of Community Mental Health Practice. San Francisco: Jossey-Bass, Inc., 1969.

Reissman, R., Cohen, J., & Pearl, A. (Eds.). Mental Health of the Poor. New York: Behavioral Publications, 1969.

Shore, M.F., & Mannino, F.V. (Eds.). Mental Health and the Community: Problems, Programs, and Strategies. New York: Behavioral Publications, 1969.

Spielberger, C.D. (Ed.). Current Topics in Clinical and Community Psychology (Vol. 1). New York: Academic Press, 1969.

A Description of Psychological Techniques and Procedures Employed for Use With Handicapped Children in the Head Start Program

Submitted by:

Cynthia Almaraz
Zadie Bergeron
Colleen Christie
Deborah Fisher
Judy Matherne

Lamar University
Beaumont, Texas
Spring, 1977

Five graduate students in psychology sought to provide psychological services by acting as consultants to four area Headstart Centers (Alabama-Coushatta Indian Reservation, Pipkin, Van Buckner, and Carver Headstart Programs). The needs of each Headstart Center evolved into an individual program for each center. However, there were some basic goals which encompassed globally all centers concerned. The students wished to foster the establishment of trust in adult and authority figures, thereby helping the child to be able to relax and get to the business of learning. At each Headstart Center specified children were given individualized or special attention as the graduate students felt necessary (assessment by psychological testing and teacher referral). The students worked at shaping acceptable appropriate classroom behavior, and at extinguishing behaviors that were judged inappropriate (such as striking or hitting another child, running around the room, etc.). Another broad goal was to increase the children's awareness of their own feelings and the feelings of others, and to allow the children to integrate this awareness into their own intellectual framework. The means by which these goals were implemented are described in the following paragraphs.

Some of the children in the centers were identified as being deficient in areas such as counting, identifying colors and gross motor skills. These children were dealt with in small groups of two or three or on an individual basis. Reinforcement was the major tool used in these situations. For example, a group of three children would be drilled using colored shapes. The child who correctly identified the color was given the shape and the child who first collected a specified number of shapes, usually three or five, was given an opportunity to blow soap bubbles. Each child usually received a chance to blow the bubbles and this reward was greeted with great enthusiasm. Attempts were made to have children of equal ability levels working together so that one child would not dominate the group. This technique was also used to teach counting and geometric shapes. A technique used to practice motor skills was the game Follow the Leader. The children could model from each other as well as the consultant. Social reinforcement was used during the game and no other reward was necessary. Individual attention included fine motor practice using a doll with snaps, buttons, etc., and practice with drawing instruments.

Another area which needed special attention was the children's facilitation with language skills. Telling the children stories in small groups and also having them participate by asking them questions concerning the plot progress and the feelings of the characters were ways to allow the children to practice verbal skills. Actively listening to the children during these sessions and in the normal course of the classroom activities encouraged them to be verbally active. This was particularly important with children in which English is the second language. There were several methods that were utilized to enable the children to practice verbal skill development while playing and in other activities in the classroom. While joining in the child's activity, the consultant asked the child questions, and had him describe what he was doing. Many children utilize pointing, nodding, and other means of non-verbal communication extensively, and these were discouraged as much as possible. These methods are not cumbersome to employ and the results can be very rewarding.

With the goal of changing inappropriate classroom behavior to more acceptable and appropriate classroom behavior in mind, several methods were undertaken to bring about the desired changes. The range of problems included such things as: (1) talking out of turn, (2) running inappropriately around the classroom, (3) striking another child with or without provocation, (4) not obeying or responding to teacher requests, (5) crying and exhibiting fear in a natural classroom situation.

Most of the children were given individual and group encounter experiences. Programs were set up to establish clear contingencies for behavior (e.g. if you do this, then that will happen). Performing the desired behavior resulted in instantaneous reward and reinforcement. Verbal as well as tangible reinforcers were used. One technique of teaching visual and auditory cues was to use a token economy system. For example, one cue was clapping the hands for immediate silence. A correct response earned a star and when five stars were earned they could be used for a trip to the play room. Another technique was to use a hand puppet to introduce verbal instructions on how to behave in social situations. A child who was observed using these behaviors was given a social reinforcer such as a hug. Finally, modeling of efficient ways to correct undesireable social behavior was used as an aid in training the teachers and aides to work with the children.

Other techniques used with children who behaved inappropriately included giving them no attention for their behavior by ignoring them or giving negative reinforcement. The aversive situation ceased when the child performed in the desired manner. For example a child who was rowdy and did not sit in his chair during group activities was made to sit on the consultant's lap and be perfectly still for ten seconds and then he was allowed to return to his chair.

This was indeed aversive for the child because he resented being treated like a "little baby."

In general these same methods were used both individually and in groups. At first even the slightest positive change in behavior was reinforced thereby producing a gradual shaping of behavior towards what was desired.

One problem encountered when dealing with the children was having them become aware of their feelings and getting them to verbalize them. It was very important that the children feel comfortable with the consultant and each other. To achieve this, art therapy was initially used with each group and the children were urged to verbalize about their pictures with the consultant and the other children. After the children became comfortable, groups were organized and various techniques used to talk about feelings including stories, books, games, and actual group processing were utilized. Varying the techniques from one week to the next was important in keeping the children interested. Stories used always reflected feelings. "The Ugly Duckling" dealt with feelings of being different, or "Pinnochio" which dealt with feelings about one's father. Books which initiated feelings about friends, family, and anger were also used. Another way in which feelings were dealt with was to play a game in which different facial expressions were displayed. The children then named the feeling and talked about when they felt this way. The children expressed their feelings with little encouragement from the consultants. These sessions allowed the children to get in touch with their feelings and to discuss in what situations they most often felt this way. Also this provided a time to discuss what other appropriate behavior could be used in specific situations.

In addition to the variety of techniques that were used to induce behavior change, other areas are important in providing services to the child. As a result of working in the Headstart program some recommendations for improvement can be made. Inservice training with the Headstart staff before visits to the schools begin would result in better communication between consultant and teacher. This would provide an opportunity to discuss realistic goals for the children and to inform the teachers of the services which the consultants can provide. A more active attempt to involve parents in the program from the outset could facilitate continuation of the program in the home. Since typically several consultants from varying fields supply services, a greater attempt should be made to coordinate the activites provided by each. In spite of the difficulties that were encountered in these areas, it was generally felt that the program provided useful services for the children involved and a learning experience for the consultants.

A Replicable Model for Immediate Intervention on Behalf of Handicapped Children

Panel Participants: Mary Cay Welsh, Ph.D., George Wawrykow, Ph.D.,
Cynthia Almarez, Zadie Bergeron, Colleen Christie,
Debbie Fisher, Judy Matherne

Introduction and Slide Presentation

Overview of the Consortium Project Which Provides Services to Handicapped Children
Dr. George Wawrykow, Coordinator of Special Services
Gulf Coast Community Services Association
Houston, Texas

The Advantages of a Community Psychology Approach for Providing Services to Handicapped Children
Dr. Mary Cay Welsh, Coordinator, Community Psychology Program
Lamar University
Beaumont, Texas

Examples of specific techniques and procedures which can be utilized.
Panel Discussants

Headstart Consultation:

A Progress Report

This is a progress report for the contracted consultation activities with the Headstart programs in Galveston County: Dickinson Headstart Center, Mainland Headstart Center in Texas City, and Ziegler Headstart Center in Galveston. The purpose of the consultation is the facilitation of improved delivery of Headstart services to handicapped children. Consultation activities began in December and January of this year and will run through the end of July. This report contains (a) a description of the consultation activities on each site, (b) a brief routine evaluation of consultation activities and relationships, and (c) a brief evaluation of Headstart services to handicapped children. The evaluation aspects of this report are attitudinal questionnaires given to the Headstart personnel. This data in no way will assess the effectiveness or extent of Headstart services to handicapped children; rather it is means to reflect the quality of the consultation activities and some indication of perceived need by Headstart personnel regarding the provision of services to handicapped children.

The Consultation Sites

Sites for consultation activities include the Dickinson Headstart Center, Mainland Headstart Center in Texas City, and Ziegler Headstart Center in Galveston. In general, consultation activities have been centered around three areas: planning and evaluation, presentations, and case consultation. The planning phase consisted of classroom observation by the consultants, as well as individual conferences between consultant, teachers and director to evaluate staff needs and establish priorities for the consultants' activities in the centers. In all these activities there is a special focus on the needs of handicapped chilren. Individual consultants' activities in the three centers are outlined below.

Dickinson Headstart Center. Presentations have consisted of both didactic and experiential sessions (including role play). Topics covered in this manner include: (1) home visits -- general concept, rationale and purpose, and preplanning steps necessary for performing these important visits, plus a role play for the actual visit in real and hypothetical situations; (2) child development -- a study of the development stages between the ages of 2-5, with emphasis on what is considered normal and abnormal behavior and the specific needs children have for physical, social and emotional growth and language development, and discussion of the handicapped child; (3) methods of discipline -- including general approaches to discipline, introduction to principles of behavior modification techniques, and application of behavior modification methods in the classroom on a specific child, with follow through and a monitoring of the effect of the program; (4) *sexual curiosity in children* -- general discussion and suggestions on effective handling of children's questions about sex, as well as their sexual play in the center; and (5) *parent participation* -- basically a discussion with staff to explore past efforts and effectiveness, and alternative ways to achieve the goal of getting parents more interested.

Case consultation is achieved through classroom observations and individual conferences with the director and the teachers about specific children they are concerned about. Specific suggestions have been given in alternative methods of handling troublesome behavior. Two of the children were used as examples in the discipline presentations. The objective of this phase of consultation is to help teachers become more skillful in dealing with troublesome behaviors and generalize and apply their skills to similar situations in the future.

Ziegler Headstart Center. After the initial sensing interviews with the director, teachers and aides, the consultant attended regular staff meetings for observation and presentations. Group meetings and discussions were used for the purpose of establishing common goals and priorities. Presentations have included (1) *child development* -- a discussion of the stages of development in children, with an overview of the preschool age child; (2) *childhood behavior* -- including causes of certain behaviors, what behaviors are considered normal; and (3) methods of discipline -- ways of handling problem behaviors based on caseful observation, with a discussion of behavior modification, stressing the role of social reinforcement.

Group discussions have focused on (1) parent participation -- with the goal of getting more parents involved, with consideration of past methods of communication and their effectiveness, and alternate methods of communicating with parents; and (2) classroom consultation -- with feedback on classroom observations by the consultant. As a result of these discussions some of the teachers agreed to work individually on improving their communication skills with parents and report the effectiveness back to the group. Individual case consultation with teachers has involved behavior management of individual children, based on classroom observations.

Mainland Headstart Center. Presentations have included the following topics, with a special orientation toward the handicapped child where appropriate: (1) types of behavior -- an examination of the variables that determine whether behavior is "normal", with the goal of understanding the reasons behind various behaviors without the necessity of labeling them as good, bad, normal, or abnormal; (2) behavior management -- a discussion of methods to use in moving children from one activity to another, emphasizing ways of facilitating cooperation by the child; (3) creativity -- a discussion of what creativity is and the best ways to encourage it, especially with handicapped children; (4) eneuresis -- a discussion of what eneuresis is, what causes it, and behavioral techniques for dealing with it; and (5) self concept -- what it is, why it is important, the factors that help determine a child's self concept, and the implications of this.

Case consultation is carried out in groups as well as individually. The consultant attends all weekly staff meetings and participates in discussion of problems regarding the presentation topics. Classroom observation is used to help teachers focus on management problems, and to observe specific behaviors of selected children when requested by the classroom teacher. Staff changes and problems with physical facility have been handled in administrative consultation.

Evaluation of Consultation Activities

After approximately five months of ongoing consultation, teachers and aides at the three Headstart centers were administered questionnaires in which they were asked to rate the quality of the consultation activities, and also indicate their felt needs regarding provision of services to handicapped children. This questionnaire is included as Appendix A. The tables in this section present center personnel's attitudes toward consultation activities and their interaction with the consultants.

The first question, indicated below, assesses the effectiveness of the various methods of intervention employed by the consultants.

1. Which areas of the consultation do you feel have been most helpful--least helpful. Place a by most helpful and an by least helpful.

   ___ Classroom observation and case consultation (discussion of individual children in classrooms)

   ___ Presentations

   ___ Group discussions

Teachers in the Headstart centers were asked to check the method of intervention which they regarded as most helpful, and put an X by the intervention method they regarded as least helpful. Unfortunately, these instructions were not strictly observed, and in some cases there were three checks on a single questionnaire. All responses are included in Table 1 below. This table is, then, a frequency table and does not reflect individual teachers. As may be seen in Table 1, group discussions were rated as the most helpful, with presentations and case consultations having an equal number of responses.

TABLE 1

Responses to Question 1, All Centers

Area of Consultation	Helpful	Not Helpful
Observation and case consultation	10	3
Presentations	10	4
Group discussions	16	0

However, presentations were regarded as the least helpful of the three methods.

In Table 2, these responses are broken down by Headstart centers. As may be seen from Table 2, the Ziegler Headstart Center rates presentations least helpful, while Dickinson and Mainland centers rate them much more positively. The Dickinson center contributed the least to the overall figures in Table 1, while the Mainland center contributed the most responses.

TABLE 2

Responses to Question 1, Individual Centers

Area of Consultation	Dickinson		Ziegler		Mainland	
	Helpful	Not Helpful	Helpful	Not Helpful	Helpful	Not Helpful
Observation & case consultation	1	2	2	1	7	-
Presentations	3	-	1	4	6	-
Group discussions	3	-	7	-	6	-

An assessment was also made of the effectiveness of relationship on both the consultant and the consultee's part in this next section of the evaluation. These tables are based on the following questions:

NOTE: All questions were scored on the following continuum:

1 2 3 4 5

2. I feel the consultant is:
   (1) very businesslike, asks good questions, makes me think.
   (5) socializes and chats, doesn't get down to business.

3. The consultant's role is:
   (1) very clear and well defined.
   (5) not clear, poorly defined.

4. I feel:
   (1) very comfortable in relating or talking to consultant.
   (5) not at all comfortable in relating or talking to consultant.

5. I feel the consultant:
   (1) asks the right questions and gets good information about the agency.
   (5) doesn't ask good questions, doesn't get information about what's really going on here.

6. I have:
   (1) been open with the consultant and trust consultant.
   (5) not been open and do not trust consultant.

7. I have:
   (1) identified clear objectives to work on with consultant.
   (5) been hazy or unclear--not defined an area to work on with consultant.

8. I feel through working with the consultant I:
   (1) have made some changes in the way I work in the classroom which I can define.
   (5) have not made changes in the way I work in the classroom.

As may be seen from the rating scale and the questions, a Likert-type scaling was used, with 1 being a generally positive response, and 5 being a more negative response. In Table 3 the average scores for all centers combined, with the number of respondents for each question, is indicated. There is an overall positive response to all the questions. In general, the teachers rate the consultants as being very comfortable to work with (Item 4), with the only difficulty lying in role clarity (Item 3), although this was still rated positively.

TABLE 3

Responses to Questions 2 through 8, All Centers

Question #	Mean	N
2	1.9	20
3	2.3	20
4	1.4	20
5	1.8	20
6	1.8	20
7	2.3	19
8	3.0	20

The teachers also tend to rate their own changes in the classroom as the least accomplished activity (Item 8), and their openness with the consultant (Item 6) as being more positive.

In Table 4, the responses and number of respondents for each of the three centers are indicated. Different patterns of responses are reflected in Table 4 across the three centers, although none of these is significant. Dickinson teachers

TABLE 4

Responses to Questions 2 through 8, Individual Centers

Question #	Dickinson		Ziegler		Mainland	
	Mean	N	Mean	N	Mean	N
2	1.0	3	2.6	9	1.4	8
3	2.3	3	2.8	9	1.7	8
4	1.3	3	1.5	9	1.2	8
5	1.6	3	2.1	9	1.5	8
6	1.6	3	1.9	9	1.6	8
7	2.6	3	2.5	8	1.9	8
8	1.6	3	3.5	9	2.8	8

rate their consultant as encouraging thought and asking probing questions (Item 2), and personnel at each of the three centers see their consultants as comfortable to work and relate with (Item 4). The most negative response noted is that of Ziegler teachers to Item 8, in which they assess changes in their own classroom behaviors through working with the consultant.

Assessment of Headstart Services

This section presents data from the questionnaires which deals with teachers' attitudes towards support services regarding handicapped children. The following questions are the basis for the information given in Tables 5 and 6:

10. I feel I have been provided with good instructions on how to work with a handicapped child in my classroom:
    (1) very well.
    (5) not at all.

11. I feel the special reports we get on handicapped children:
    (1) are very clear and helpful for classroom activities.
    (5) are not at all clear or helpful for classroom activities.

12. I feel I have been provided with clear and useful training in meeting the special needs of handicapped children:
    (1) very well.
    (5) not at all.

13. I feel that the support and help we receive from other agencies in dealing with handicapped children is:
    (1) very beneficial.
    (5) not at all beneficial.

Table 5 includes combined results from all three centers, given as mean score and number of respondents to each question. As in previous tables, a score closer to 1 is more positive,

TABLE 5

Responses to Questions 10 through 13, All Centers

Question #	ALL CENTERS	
	Mean	N
10	2.5	20
11	2.6	20
12	2.9	20
13	2.8	20

whereas a score closer to 5 reflects a negative assessment. There is an overall trend toward positive assessment, as can be seen in Table 5. However, these responses are not as positive as in tables previously discussed.

Table 6 includes data from each center individually. As can be readily seen, Ziegler personnel tend to give a more negative view of support services, while Mainland personnel rate them in a generally more positive way. Scores from the Dickinson center are split between positive and negative

TABLE 6

Responses to Questions 10 through 13, Individual Centers

Question #	Dickinson		Ziegler		Mainland	
	Mean	N	Mean	N	Mean	N
10	3.0	3	3.0	9	1.8	8
11	2.6	3	3.0	9	2.0	8
12	3.3	3	3.2	9	2.4	8
13	2.6	3	3.3	9	2.1	8

assessment. Responses to Question 12 indicate the area of greatest felt need, while those to Question 10 were most positive; however, these differences are quite small.

The final question to be analyzed reflects felt problems or needs of personnel. The data in Tables 7 and 8 are based on the following questions:

9. Please check the three items which are problems or needs for you in your job.

___ 1. Having new teaching materials
___ 2. Working with parents
___ 3. Filling out the forms, lesson plans
___ 4. Going to the workshops
___ 5. My personel career development
___ 6. Getting the kids to behave
___ 7. Getting along with the other teachers
___ 8. Making sure health and nutrition guidelines are followed
___ 9. Knowing how to help a child with a special problem
___ 10. Knowing what is reasonable to expect from a child
___ 11. Knowing how to teach
___ 12. Other (specify) ______________________________

Data in these tables are given by the frequency with which they were checked by Headstart personnel.

Table 7 gives the combined responses for all three centers. Most frequently mentioned problem areas are having new teaching materials (Item 1) and working with parents (Item 2). Items not mentioned as problems by any of the center teachers include going to the workshops (Item 4), getting

TABLE 7

Responses to Question 9, All Centers

Item #	ALL CENTERS
1	12
2	13
3	3
4	-
5	7
6	3
7	-
8	6
9	5
10	3
11	-
12	-

along with other teachers (Item 7), and knowing how to teach (Item 11).

Table 8 gives the results of Question 9 by individual centers. Again, the most frequently mentioned problem areas mentioned by Ziegler and Mainland teachers are having new teaching materials and working with parents (Items 1 and 2); these items are not mentioned at all by Dickinson personnel. The item listed by Dickinson personnel as the most felt need was personel career development (Item 5).

TABLE 8

Responses to Question 9, Individual Centers

Item #	Dickinson	Ziegler	Mainland
1	-	6	6
2	-	5	8
3	2	-	1
4	-	-	-
5	3	-	4
6	1	2	-
7	-	-	-
8	-	4	2
9	-	3	2
10	1	1	1
11	-	-	-
12	-	-	-

children's mental health services of houston
guidance, consultation, early childhood, ima hogg school, habilitation divisions

director
ames s. robinson, m.d.

administrative director
grayson c. clemons, m.p.h.

A CENTER-BASED MODEL FOR CONSULTATION RELATING TO THE HANDICAPPED CHILD

by: Cay Cannady, Director
Early Childhood Division

OBJECTIVE:

In January, 1977, the Early Childhood Division of Children's Mental Health Services (CMHS) contracted with Gulf Coast Community Services Association to provide consultation services to the Hitchcock Head Start Program for a cost of $7,400.00 plus travel expenses. The goal of the contract was to provide consultation to the Hitchcock Head Start staff that would enhance the services they were providing to handicapped children enrolled in their program.

CENTER-BASED DESIGN:

In order to best attain the objective, the diagnostic, training, and follow-up services provided for under the contract were designed to be delivered at the Head Start Center. Once a week the consultants from the Early Childhood Division, CMHS visited the Head Start Center for approximately three hours. The center-based consultation provided an optimum use of staff time, in that it allowed all Head Start staff to participate in the consultation and eliminated their need to travel. This center-based model also provided an opportunity for the consultants to observe the children's behavior and staff's behavior during the course of a typical day at the center. It is felt that these observations enriched the diagnostic and follow-up services provided. The center-based model also enabled the children to be tested in familiar surroundings.

a united fund agency
3214 austin street telephone 713 526-3232 houston texas 77004

DESCRIPTION OF DIAGNOSTIC, TRAINING AND FOLLOW-UP ACTIVITIES

Plan for Consultation Activities:

An initial meeting was held with the Head Start Staff to review the plan for consultation and to establish guidelines and procedures for carrying it out. The following procedures were developed.

1. Head Start staff would observe the children enrolled in the program and complete the Kohn Problem Checklist for each child. (Appendix A)
2. CMHS consultants would score and review all Kohn Problem Checklists. Conferences would be held with the Head Start staff to discuss the status of the children who had scored significantly below the mean.
3. CMHS consultants would observe the children participating in their regular classroom activities and confer directly with the staff regarding their observations and concerns about the children.
4. Children would be selected for developmental evaluations. The Head Start staff would secure parent permission and information from parents regarding the child's developmental history. (Appendix B and C)
5. CMHS consultants would schedule diagnostics at the Head Start Center and a written report would be submitted to the Director. The report would indicate the handicapping condition of the child, according to Head Start criteria, and include recommendations for remediation of the child's handicap.
6. CMHS consultants would provide follow-up services as needed.

Implementation of Plan:

Two additional meetings were held with the Head Start staff to train them in observing children and establishing guidelines for the identification of children with handicapping conditions. During these meetings, the staff were trained in the use of the Kohn Problem Checklist in order to facilitate their identification of children with handicapping conditions. This checklist yields two scores. One score is a measure of the child's interest and participation in the classroom activities versus apathy and withdrawal. The second score is a measure of the child's cooperation and compliance with the classroom structure and rules versus the child's anger and defiance.

The staff rated fifty-five children using the Kohn Problem Checklist. These checklists were scored by the consultants and reviewed with the staff. A total of nineteen children (35%) scored minus one standard deviation below the mean on one of the scores. Three of these children had been diagnosed the previous year as having handicapping conditions, and their progress was reviewed with the staff. All of the nineteen children were reviewed with the staff and a total of seven children were identified that needed developmental evaluations. The other children were observed in the center and recommendations made regarding their management. Of the seven children evaluated, four were diagnosed as emotionally disturbed, one was diagnosed as having a communication disorder with indication of developmental impairment, and two were diagnosed as having no handicapping condition according to Head Start criteria.

Follow-up services included: 1) Conferences with staff regarding the interpretation of the developmental evaluation and recommendations made regarding the remediation of the children's handicapping conditions. 2) Conferences with four parents to interpret the results of the evaluations and to make recommendations to the parents regarding their child's special needs. 3) Direct work with children in the Head Start Center to remediate their handicapping conditions and to provide modeling for the staff. 4) Two workshops were held to discuss the emotional development of children and to present guidelines for working with children with emotional handicaps. 5) Consultation was provided to the Head Start staff who make home visits and training was given in the use of the Portage Guide to Early Education. The focus of the consultation was to help the Head Start staff increase the parents' awareness of their child's special needs and to provide guidelines for the parents to provide for these needs within the family context.

RECOMMENDATIONS FOR CHANGES IN THE CONSULTATION CONTRACT:

The Hitchcock Head Start Center opened in August, 1976, and closed July 1, 1977. The CMHS consultation contract covered the period from January, 1977, through July 31, 1977. This five-month period enabled earlier identification of children and earlier initiation of remediation, as compared to the two-month contract period in 1976. However, both the Head Start staff and the CMHS consultants feel that the consultation contract would be most effective if it could be initiated at the beginning of the school year. This would enable the completion of diagnostic services by November and the remainder of the contract could be fulfilled by providing follow-up services to the Head Start Center. This earlier beginning date would provide an opportunity to identify the children with handicaps in the beginning of the school year and consequently intervention could be initiated earlier.

University of Houston
HOUSTON, TEXAS 77004

Department of Psychology

Aug. 23, 1977

Dr. George Wawrykow
Head Start Coordinator of Special Services
Gulf Coast Community Services Association
6300 Bowling Green
Houston, Texas 77021

Dear Dr. Wawrykow:

Psychological consultation to the Texas City Head Start Center was carried out by Kirk Goddard, Linda Selesky, Daniel Labasse, Artin Goucu, Stella Garcia and Ursula Diaz-Albertini under my supervision. The center was visited on several occasions and I accompanied the student-consultants on all but one of these visits.

In the first two visits, we asked the teachers about children with what they perceived as learning problems. An effort was made to obtain a general overview of the teachers' perceptions of these children, particularly from the standpoint of their experience with the children in the classrooms. A rather long list of children with problems emerged. The number of children with problems of various kinds were as follows:

	N	%
Total	60	100
Visual Impairment	6	10
Hearing Impairment	2	3
Speech Impairment	34	57
Health or Development	30	50
Emotional Disturbance	15	25
Learning Disabilities	35	58
No evidence of handicap	5	8

As may be seen, the percentage of children cited as having speech impairment, poor health or development or learning disability is very high. Although fewer children were to be emotionally disturbed, the 25% rate was also higher than expected. Only 8% of the children were regarded as showing normal development or learning.

We felt that the first thing to do was to examine the sources of information about the children. They were of two types: direct observation of the day-to-day behavior of the children and screening test results. Texas City Head Start children are screened twice a year by a team from the Texas City Independent School District.

With the student-consultants acting as classroom observers we found some support for the teachers' impressions, but also obtained the impression that a number of children were behaving well within normal ranges and should probably not be regarded as exceptional.

We also found on reviewing the screening results that a large number of children received very low scores on the Peabody Picture Vocabulary Test (PPVT). That test has been shown in a large number of research studies to yield low vocabulary scores with young children of low income families (compared with other tests such as the Stanford-Binet).

We decided to cross-check the PPVT results with those of another widely-used, brief measure of intelligence, the Slosson Intelligence Test. Only 23 of the 60 children were tested. Both PPVT and SIT were given within a period of about one month. The results of the two tests are shown in Table 1. Quite clearly, the PPVT yielded lower scores than the SIT and the difference especially striking when one notes that 6 of the PPVT scores were 70 or below and none of the SIT scores were that low.

It is difficult to know just what to make of such wide differences in test scores. Certainly, the PPVT again has been found to yield too many low scores. On the other hand, it is also striking that there were really no low scores on the SIT. I have had considerable experience with both tests with Head Start children and have found that the SIT does identify truly retarded children when tested and that we were most likely obtaining a valid measure of the child's intellectual ability. It is our opinion, therefore, that there were no really retarded children among the Texas City group.

This concern with the tested performance of the children occupied quite a bit of the consultants' time and other issues had to be given less attention. Discussions were held with the teachers about problems presented by specific children and recommendations were made about how the problems could be handled.

The consulting visits have led to several recommendations.

1. Drop the PPVT from the screening battery and either replace it with a more appropriate test or place more reliance on teacher ratings of the child's functioning.

2. No Spanish-speaking children should be tested by examiners who are not fluently bilingual. The Texas City program has a number of Spanish-speaking children and will probably have more in the future. These children may be expected to do poorly on English-language tests and the assessment of language fluency calls for some skill. Just because a child responds to English with a few English words does not mean that he or she is fluent in the language.

3. Spanish-speaking teachers or assistant teachers should be present in classrooms that are attended by Spanish-speaking children.

4. The teacher-pupil ratio at the Texas City center are too high. There should be 4 teachers for 60 children.

Although, it was our impression that the number of children at the Texas City center with various learning problems was somewhat lower than reported, we have also come away with the impression that a number of the children will need special attention before beginning public school. The teachers will also need consultative assistance with these children.

If we have an opportunity to provide consultative services next year we will be able to place less emphasis on testing and more on helping with curriculum development, classroom management, and with the problems of specific children.

The student-consultants and I found the experience at Texas City interesting and rewarding. We were all impressed by the warmth and concern of the teachers for the children and with the lively enthusiasm of the children.

Sincerely,

Dale L. Johnson, Ph.D.
Professor

DLJ/lp

TABLE 1

TEST RESULTS

CHILD	TESTS PPVT	 SLOSSON	
A	81	106	
B	78	100	
C	56	102	
D	77	82	
E	69	90	
F	78	100	*
G	81	91	*
H	67	88	
I	83	98	*
J	83	102	
K	--	86	*
L	100	116	
M	97	95	
N	63	94	
O	92	118	*
P	101	113	
Q	103	106	
R	81	98	
S	72	90	
T	70	95	*
U	59	90	
V	92	68	
W	92	110	
X	97	103	
Mean	81.39	98.91	
N	23	23	

r= .57

* Bilingual examiner

Family Service Center

of Brazoria County

Member: Brazoria County United Fund, Family Service Association of America

215 Flag Lake Drive
Lake Jackson, Texas 77566
Phone (713) 297-3066

Marti L. Jones, M.A.
District Director

HEAD START PSYCHOLOGICAL CONSULTATION SERVICES REPORT AND RECOMMENDATIONS

May 30, 1977

The major portion of the consultant's time this spring was spent observing each of the children in his/her routine Head Start activities.

Behaviors being evaluated were:

1) interpersonal relationships with peers as well as with teachers.
2) methods of coping with authority, the learning process, social interaction, and the handling of stress and frustration.

A number of parent conferences were set up -- either at Head Start or in the child's home. These were to gain and/or give information, or to ask the parents' cooperation and participation in carrying out some plan of action related to their child.

Several meetings were held with the staff to determine needs, to exchange information, to plan means of handling specific behavior, and to report and evaluate results.

The staff members were very cooperative and cordial to work with. It was a pleasure to observe their expertise in teaching and in gaining the cooperation of the children, seemingly with such ease and calm!

Some possibilities or suggestions for consultant activities for next year that might be productive:

1) more home visits
2) introductory meetings with parents (and perhaps periodic follow-up meetings.)
3) regular meetings with the staff (at least once a month.)

This agency is affiliated with Family Service Center of Houston and Harris County, 3635 West Dallas, Houston, Texas 77019

E. F. Christman, Jr., Executive Director

General suggestions

1) where appropriate, staff reports be forwarded to kindergarten teachers with a child.
2) set up team approach so the different disciplines working with the children might share their information more productively through joint meetings.

Marti Jones, Psychological Associate

mj/pbs

Report of Consulting Activities
In the Abell Street School

This report represents a discussion of the outcome of our involvement with the Abell Street Headstart Center as consultants. We were invited into the Abell Street Headstart Center by Dr. George Wawrykow, co-ordinator of Special Services for the Gulf Coast Community Association. The purpose of the invitation was to consult and assist in the development of a treatment program for those children within the Headstart program who were either physically, socailly, or intellectually handicapped as specified by the Office of Child Development's criterion. Our intention was to effect the children of the Headstart program and their families through working with the teachers and administrators of the center.

The situation. The Abell Street Headstart Center located in Wharton, Texas, is a rural farming and ranching community with a population of 9,000. The Headstart Center shares the Abell Street School building with the Abell public school kindergarten. It is worth noting that the Headstart Program in Wharton Texas is a part of the overall public school program for that community which provides a smooth transition into the regular public school program for the children of Headstart. The Abell Street Headstart Center provides pre-school services to 64 children, most of who are Balcks or Chicanos required by the national guidelines of Headstart programs all the children were from low socio-economic families.

The faculty of the Headstart program consists of one head teacher - Mrs. Spano, three teachers - Mrs. Kramer, Mrs. Jordan, and Mrs Sanford, and four teacher's aides. Of the teachers, two are Black and two are white. There are three Chicano and one black teacher's aides. Although not formally responsible to the program, the principal, Mrs. Nash and the school nurse, Mrs. Kolle, contribute valuable time and effort toward the operation of the Headstart program.

Goals. From classroom observations, it would appear that the principle goal of the program is to provide the child with adequate cognitive skills. This includes providing the child with proper modes of language usage, and conceptual and verbal fluency. Other goals emphasized by the program appeared to be the development of perceptual and motor skills and the provision of health care training and services. The Abell Street Headstart Program does a good job of training the children in the areas of cognitive, perceptual and motor skills.

From our observations and the self-reports of the teachers, the social development (social interaction, social studies, and discipline) and moral development were not clearly defined nor adequately represented in the program. The teachers reported that their social development program consisted mainly of trips to significant places outside the experiences of the children and encouraging interactions between the children. It was agreed by the teachers and the consultants that attention would be focused on assisting with defining and devising a program directed at social development. Specifically, the teachers felt the children needed to learn self-discipline. In addition, it was agreed that the strengths and competencies of the children had to be fostered. Hence the resulting social development program focuses on behavioral management as well as enhancement of individual competence and strengths. The goal of the social development program was to encourage confidence and curiosity in the children.

The intervention. A series of workshops which consisted of discussions, roleplaying, and re-enactment were presented to the teachers. The workshop provided the teacher with training in child competency development. The child competency development program requires the teacher to record incidents in which she had observed, approached, and rewarded a child for participation in some appropriate activity. The intention of this program was to get the teacher to develop 1) an awareness of "good" behaviors in a child , 2) a pattern of rewarding the child with both physical (touching) and verbal (praise) positive reinforcement. Once the child was recognized for some achievement, he would more readily increase his attending behavior and would find learning enjoyable. Initially, the teachers were to select the pupil she felt was especially withdrawn or disruptive. She was to note when the child was appropriately involved in some activity and reward the child for doing so.

A second aspect of the program focused on the use of time-out procedures. Essentially if a child is acting out and disrupting a classroom, he was deprived of some identified rewarding object or activity until he demonstrates that he can control himself then he is rewarded for his control by having the deprived object returned. The teacher identfies an area of the classroom that could serve as a time out space. When a child was disruptive he was sent to "time out" for a period of five minutes quiet time, after five minutes of quiet time he could return to the activity.

Evaluation of the program. Because of a limited amount of time, a fair evaluation of the effectiveness of the program was not possible. However, we were able to discern from teacher's and our own observations a general impression of the effectiveness of the program intially the teachers felt that we were there to criticize them without listening to them. Their experience with consultants in the past had been extremely aversive because the consultants were highly critical of their program without offering any practical suggestions.

The teachers agreed that the program enabled them to focus on the strenghts of the children more, however it was clear that they were not sold on the total package. For some children focusing on positives appeared to effective, but the teachers still viewed this as remediating deficits. It was not clear how often the children were getting positive attention and if the positive attention was contingent on spontaneous activities or appropriate activities which were in some sense new to the child. The recording forms were finally used before the last session (perhaps a sign that the teachers were more willing to examine the total program) but they were still used incorrectly (strenghts not being listed, negative interactions were recorded, etc.).

By the final workshop, it appeared that the teachers were more co-operative and had some confidence in the principle of focusing more on the positives in the child. They recognized that they did these things already, but that it was more explicit and intentional. If further time had been available, then it is likely the teachers would have implemented the program to a greater degree under our encouragement, and we could have better monitored their implementation. The teachers remarked that our coming into the classroom to model the implementation of the principles with the children would have been helpful; also if we had observed their interactions. It was agreed that this was a valid suggestion which would also have sensitized us to difficulties in implementation which we were unaware of otherwise. The idea of including aides in future meetings was also introduced.

Our impression was that the teachers, some more than others, appear to focus to a greater degree on the children's strenghts, although they are not convinced of its effectiveness (which is reasonable, they will probably be better able to test out its effectiveness next year). That is, we have sensitized them to use this approach with children, and appear to have laid the foundation for future interventions in the classroom.

Louis Anderson
Steve Slaten
Supervised by:
Dr. Melvin Wilson

Proposed Evaluation of Head Start Services to Handicapped Children

James K. Esser, Ph.D.
Department of Psychology
Lamar University

A joint project is proposed involving the Lamar University Psychology Department and the Gulf Coast Community Services Association. The proposed project is designed to evaluate the effectiveness of services rendered to handicapped Head Start children at the Alabama/Coushatta Indian Reservation, Carver Center, Van Buckner Center, and Pipkin Center in 1977-78. These children have been diagnosed as handicapped according to at least one of the following criteria: blindness, visual impairment, deafness, hearing impairment, physical handicaps, speech (communication), health or developmental, mental retardation, emotional disturbance, and specific learning disabilities. In particular, the proposed project can evaluate services to these children rendered by the Lamar University Speech and Hearing Center, and by the Lamar University Psychology Department.

Most psychologists do not question the potential value of preventative and corrective programs for physically, psychologically, socially, or educationally handicapped pre-school children. Indeed, Head Start programs designed to provide these early services to children can take advantage of critical periods in the children's development - a period in which the introduction of specific educational materials and experiences has maximum potential influence. This proposed evaluation project is designed to provide an objective basis for creative change and development of the treatment programs servicing the local Head Start Centers.

Objectives:

There are two main objectives of the evaluation project. First, the overall effectiveness of the local Head Start services to handicapped children will be evaluated. This type of evalution, of course, will provide justification for the continuation of the excellent services provided by the local Head Start programs for the handicapped. It is true that at the national level recent research has been quite encouraging regarding the effectiveness of Head Start programs. However, such global national evaluation research cannot adequately reflect the strengths of our local Head Start services to the handicapped. Indeed, the efforts of our local Head Start programs are generally most encouraging. The proposed project will provide substantial objective evidence of the overall effectiveness of the local Head Start programs, based on appropriate research design and statistical analyses.

Second, the local Head Start centers provide various services to handicapped children. They employ different personnel and different techniques to meet the unique needs of each child.Therefore, it is necessary to tailor the evaluation to the idiosyncracies of each program. By using this specific, tailored evaluation approach the strengths of each program will be demonstrated. In addition, the proposed project will provide a comparison of the effectiveness of these different treatment services within each local Head Start center. This local program evaluation can be the key to continual refinement of service techniques. Only through explicit evaluation of program effects can worthy approaches be retained and refined, and ineffective techniques dropped. In addition, such local evaluations can provide critical feedback and deserved rewards for the teachers and service personnel. It is proposed that this 1977-1978 program of evaluation may serve as a model for a continuous monitoring/evaluation system which also can be used in the training of new teachers in the most effective service techniques.

Personnel:

The proposed evaluation project will be conducted by student consultants in close cooperation with the Head Start Director and teachers at each center. These student consultants are advanced graduate students in the industrial psychology program who are enrolled in a practicum under the supervision of Dr. James K. Esser and Dr. James R. Hawker of the Psychology Department Faculty. These student consultants have an extensive background in both theoretical and applied psychology, including a working knowledge of child and developmental psychology. In addition, their specialization in industrial psychology provides them with excellent training in statistics and sophistication in the techniques of evaluation research.

Method:

In order to objectively evaluate the effectiveness of the various Head Start services for the handicapped--each with unique problems and goals--a number of requirements must be met. First, outcome measures must be developed which (a) can be objectively and unambiguously scaled, (b) allow reflection of better-than-expected success, as well as break-even or failure outcomes, (c) allow comparison of goal attainment even when different goal attainment criteria are employed, and (d) are amenable to statistical analysis. These criteria are satisfied by a commonly used system called Goal Attainment Scaling.

Second, sound experimental or quasi-experimental designs stand as guides to logical evaluation. There are a number of threats to accurate evaluations--influences other than the actual service to be evaluated. These include: natural changes over time, such as maturation of the child; biased selection of children or circumstances to be evaluated; and statistical regression--the tendency for anything which is initially extreme to revert, on the average, toward the less extreme. These pitfalls can be avoided by the use of good experimental or quasi-experimental designs which incorporate appropriate comparisons of various service techniques, and by appropriate statistical analyses.

Third, in order to make efficient use of the findings gleaned from the evaluation of the Head Start services for the handicapped, three conditions will be met: (1) The results will be distributed to all interested parties. Such dissemination of results will lead to wider interest in these Head Start programs, as well as providing an incentive for continual improvement. (2) The results will be reported in the form of specific recommendations which can be readily implemented in the continual improvement of the Head Start services for the handicapped. (3) A model evaluation system will be established so that a continuous monitoring/evaluation program can be employed for more efficient planning and change in the Head Start services for the handicapped.

Benefits:

The proposed evaluation program can be mutually beneficial. The most important of these benefits is the potential to provide better and better services to Head Start handicapped children by evaluating and refining service techniques. Moreover, this proposal offers professional services which would be financially prohibitive should professionals in private practice be employed.

In addition, this proposal allows the Psychology Department to expand the range of educational experiences for our graduate students. This important experience in applications of their academic training will certainly be of great professional benefit to these students.

Summary:

An evaluation project is proposed which will benefit both the local Head Start programs in the Gulf Coast Community Services Association and the

Lamar University Psychology Department. It is expected that this joint project will aid in the efficient provision of preventative and corrective programs for handicapped pre-school children at a critical stage in their development. In order to maximize the potential for change which Head Start programs have, it is imperative that the problems of the children be detected early and that corrective measures be taken immediately before possible psychological damage becomes irreparable. The program approach initiated by the Gulf Coast Community Services Association is laudable, and the Lamar University Psychology Department is pleased to be able to aid in the evaluation and continued improvement of these programs.

SPEECH

HEARING

LANGUAGE

Head Start and Speech/Hearing/Language Services

Annual Report

The Lamar University Speech and Hearing Center has provided services to Head Start children in the surrounding Beaumont-Woodville area since January of this year. The following narrative is written as a summation of the services and as a description of the rationale for their continuation.

We have been serving children from the Alabama/Coushatta Indian Reservation, Carver Center, Van Buckner Center, and Pipkin Center. Head Start children from these centers have received screenings, diagnostic evaluations and direct therapy for speech, language and hearing problems.

THE SPEECH AND LANGUAGE PROGRAM

Program Development, Screening and Diagnostic Proceding: The speech and language program began with an inservice with Head Start personnel at the new Lamar University Speech and Hearing Center. The Head Start people participated in the initial planning stages and the types of evaluation and special services which Lamar Speech and Hearing Center can provide were described. A tour of the new million dollar speech and hearing clinic was taken and the new diagnostic and therapeutic equipment was demonstrated. At this initial visit, channels of communication adn cooperation were developed. Scheduled were then arranged and during a one week period each of the children from the four centers were transported to the Speech and Hearing Center in vans or a bus provided by Lamar University. During this first visit, each child was screened for the possibility of speech and /or language problems which could have educational, social, psychological or developmental implications.

A total of 170 children were seen for the initial screening process. Children who failed the screening tests were then given a complete diagnostic evaluation to determine the extent of their problems and the advisability of intervention procedures. From this original group of 170 children, three were found to have articulatory speech disorders, twenty-nine had language problems, and five were found to have a combination of speech and language abnormalities. It would be noted that these speech and language problems were not of ethnic origin and that the decision to place a child in therapy was made only if the child was at least 2 years behind the norms for speech and/or language development.

Speech and Language Therapy Program:

Since the completion of the screening and evaluations, we have been providing direct services to those children identified as having communication and/or linguistic processing problems. To provide this therapy, we have sent teams of graduate students to the Head Start Centers to work directly with these children. These graduate students have completed their B. S. degree in Speech Pathology and most hold teaching certificates in such areas as Speech and Hearing Therapy, L.L.D., and/or Elementary Education. The students are supervised and directed by Lamar University staff members who are certified clinically compe tent by the American Speech and Hearing Association.

The actual therapy which these children have received has varied, depending on the problem. If the problem was one of articulation or speech disorders, therapy has consisted of such activities as auditory discrimination training, modeling practice and production/habituation procedures. The children with language problems may have received help on vocabulary, morphology, and sentence structure. Therapy has often involved interaction with and inservice for the Head Start personnel. Parent counselling procedures were required in some cases and at times the Lamar University staff and students demonstrated activities to the parents which should enhance speech and language development in the home.

Individual records have been kept on each child and term end reports have been forwarded to the Head Start programs involved. See Appendix A for the term end reports. In addition to supplying term end reports, we have supplied the Head Start Programs with copies of our screening and diagnostic evaluation reports. Also, we have provided the Head Start personnel with copies of our daily lesson plans andobjectives. Giving our lesson plansto Head Start has often lead to our suggesting to the Head Start teachers some activities which could be used in the classroom to encourage normal speech and language development of the entire group.

Justification for Speech and Language Therapy with young children

We are not always certain why speech and/or language fails to develop normally. As with most developmental processes, there are those youngsters who are considerably advanced in speech and language development, and there are those whose speech and language develops in a slower or even in a deviant manner. Researchers in speech and language have indicated that physical or functional factors or a combination of the two can contribute to abnormal development, but it is often difficult, if not impossible, to determine the etiology of a speech/language problem in any given case.

While we may not always know the cause or causes of these problems, we do know that they can have negative social, psychological, educational and familial effects if left unresolved. Children with communication problems are often reluctant to attempt to talk. When such a child does try to speak, the responce from adults and from his peers may be such that damage to the self-image can result.

Of primary interest to educators is the correlation between speech and language problems and later educational achievement. We have known for some time that speech, language and reading can not be clearly separated. Our research has shown that one cannot clearly separate reading disabilities from language disabilities from learning disabilities. All of these factors are related to the processing of language in some form. Speech and language specialists are trained to identify these problem in language processing, and to develop procedures for reducing the problem. We have repeatedly found evidence of the reduction and/or the elimination of the handicapping influence of communication based problems. The motivation behind Head Start is to seek out youngsters whose present rate of development is deficient and who have a high likelihood of being handicapped in their later school years. The speech therapist provides special services to the communicatively handicapped to prevent these children from being misunderstood by their parents, socially maladjusted, and educationally handered.

Mention should be made of the language patterns used in the homes of these children. The Alabama/Coushatta Indian children and the Black children often come from homes where standard English is not the primary mode of communication. In these cases, the speech and the language of the children is usually affected. It is our opinion, and the opinion of most writers in speech and hearing today, that all languages should be considered equivalent. That is, it is not correct to assume that English is superior to a foreign language or to a dialect of English. By this reasoning, we have not included children in speech and language therapy if their "problems" appeared to be more related to a dialect than to a "true" speech/language problem relating to organic and/or functional causes.

THE HEARING EVALUATION PROGRAM

Like the speech and language program, the hearing evaluation program began with an inservice meeting with the Head Start staff and the Lamar University Speech and Hearing faculty. The hearing evaluation procedures were explained and a set of earphones was given to each of the centers so they could "practice" with the children. The children from each of the centers were then transported to the L. U. S. H. center for hearing screening procedures. These screens occurred on the same day that the speech and language screens took place. Following these screening procedures, children with suspected problems were transported by Lamar University staff and vehicles back to the Speech and Hearing Center for complete testing.

The Head Start choldren were tested by Dr. O. T. Pederson and his crew of graduate audiology students. Dr. Pederson has a Ph.D. in audiology from the University of Oklahoma Medical Center and is certified by the American Speech and Hearing Association. The children were tested with the latest in audiometric equipment. This equipment, valued in excess of fifty thousand dollars, is located in sound-proof test suites within the new million dollar Speech and Hearing Center.

At present, we have completed the hearing evaluations on 95 of the Head Start children and have the remainder of the children scheduled for evaluations later in the week. Of the children scheduled for evaluations later in the week. Of the 95 children tested, about 75% have essentially normal hearing sensitivity. The remaining 25% (23 children), have been found to have hearing losses of such magnitude as to necessitate referral for medical assistance. We have identified at least 10 children with hearing problems profound enough to affect social, educational and personal development.

The identification and assesment procedure had been followed by referral to medical personel with whom we work closely in seeing that these children are treated. In all of the 23 children we have found to date with hearing problems, none have had losses that were not medically treatable. That is, we have not found sensorinewral losses in these youngsters. Rather, the identified losses have been conductive in nature and these are usually related to medical pathologies. This means that our audiological assessment procedures have made it possible for us to make referrls for medical treatment which can, in turn, make it possible for the children to have their hearing problems treated. This means that wasted years and educational, social and developmental handicaps can be prevented.

Copies of all recommendations and referrals have been sent to the Head Start programs. Copies of these reports can be found in Appendix B.

Costs of these Special Services:

Using graduate students and considerablevolunteer time from L. U. S. H. faculty has kept the actual costs of these services to a minimum. To date, the time breakdown is as follows:

Audiological Assessment:	
Student time:	400 hours
Consultation time:	20 hours
Report writing:	30 hours
Speech and Language:	
Student time:	404 hours
Consultation time:	20 hours
Report writing	45 hours
Secretary time	125 hours

In addition, we have provided transportation of the Head Start children to and from the Speech and Hearing Center as well as the transportation of the speech therapists and supervisors to and from the Head Start Centers. These transportation costs have been considerable, since the distance between the Indian Reservation at Woodville and the L. U. S. H. Center is in excess of 70 miles one way.

If we were to consider the value of the graduate student time to be at $15.00 per hour, the 804 hours would be valued at $12,060.00. Professional time spent in supervision, consultation and report writing has been in excess of 438 hours.

Professional time in our field is usually computed at $30.00 per hour. This brings the value of the professional time to $13, 140.00. Transportation costs have totaled about $2,000.00 to date. Discounting any charges for the use of our equipment and testing facilities, or for secretarial time, this brings the value of our services to $27,200.00. Our actual billing to the Gulf Coast Community Services Association will total $7,520.00 for supervision and approximately $2,000.00 for travel expenses for a grand total of around $9,520.00. In summary, this means that the Head Start children have received direct special services by graduate students and staff of the Lamar University Speech and Hearing Center valued at over 27 thousnad dollars for a little over 9 thousnad dollars. When one considers the value of the services and the fact that there were no charges for rquipment use, equipment operation and supplies, nor for supplies associated with the evaluations and therapy; the "bargain" becomes even more apparent.

Suggestions for changes in the 1977-78 Program:

Recommendations for improvements in next year's program are as follows:

1.) We have provided special services to these communicatively handicapped children from January until May.

2.) The parent counselling and suggestions for home training programs should be expanded.

3.) Periodic inservice conferences should be scheduled throughout the year between Head Start personnel, L.U.S.H. staff, and other agencies serving the children.

4.) The program should be expanded. Currently, we are seeing only those children who have speech and language dificits which range from one to three years below the norms for their age group. Since these children are only about 4 years old, we may well want to work with children who indicate a 6 month deficit.

5.) Closer cooperation between the Lamar University Psychology Department and the L. U. S. H. Center should be maintained. Both of these programs are servicing the same Head Start children and cooperation on inservice, diagnostics, therapy, parent counselling, etc. should be established.

HEAD START
Speech/Hearing/Language Services
Evaluation Report

Diagnostic and therapeutic services were provided by Ms. Marjorie Hughes to the following Head Start programs: 1) Washington Head Start (Texas City Independent School District, and 2) Central Day Care Association. Services were provided to the Washington Head Start Program from January through May of 1977. From January through July of 1977 services were provided to the Central Day Care Association.

The following was determined to be the pertinent needs of the Head Start programs:

1. Identification of speech, hearing, and language problems of the Head Start children.
2. Establish program for language impaired children.
3. Establish articulation groups for speech impaired.
4. Formulate a list of handicapped children.
5. Explanation of testing and results to teachers.
6. Order materials and equipment and organize a system for use for therapy and for classroom activities.

From this list of needs, certain short and long term goals were formulated.

Program Goals:

1. Complete speech and hearing screenings on each child in each of the Head Start Centers.
2. Diagnose speech and hearing disorders of identified individual pupils.

3. Serve as a consultant to teachers in classroom management of pupils with speech and hearing and learning problems.

4. Organization of speech and hearing folders.

5. Structuring of speech and hearing folders for similarity among sites.

6. Structuring of diagnostic materials and concepts among sites.

7. Structuring of therapeutic materials and concepts among sites.

8. Structuring of children referred for speech therapy to meet the most critical needs:

   a. individual therapy

   b. group therapy

   c. therapy in the classroom

9. Structuring referral sources.

Analysis of Goals

1. Speech screenings were conducted on a teacher referral basis. Materials used for the screening were donated by an outside source.

2. Speech and language diagnostics were conducted by the Center for Audiology and Speech Pathology, UTMB-Galveston, Galveston, Texas. Six children were evaluated. The remaining children were on vacation during their scheduled appointment times.

3. Appropriate time was utilized in each classroom setting with both the teacher and children. Workshops and informal discussions were conducted regularly.

4. Each child's speech folder was arranged in such a manner that it contains appropriate information concerning his particular problem and recommendations.

5. All folders among sites are similar.

6.-7. Diagnostic and therapeutic materials were never received.

8. Individual and group therapy sessions were arranged in each center. Ten children received individual sessions weekly with thirty children receiving group therapy. The remaining sixty children received additional speech and language stimulation within the classroom setting.

9. Attempts were made to organize a list of referral agencies that could, in any way, be beneficial to those children receiving speech and language services. Additional work should be done in this area.

DISCUSSION

The teachers in the Head Start program were receptive to the recommendations concerning their individual children, and improvement was noted in the area of teacher-pupil relationship. It was very difficult to schedule therapy sessions at the centers due to conflicting activities. It was even more difficult during the summer sessions because of outside activities such as swimming and field trips. There is a definite need for therapeutic and diagnostic materials in speech and language.

In April Mr. Gerald Miltenberger, Director, Center for Audiology and Speech Pathology, UTMB at Galveston, was contracted to serve as a consultant and advisor. The needs and goals were discussed and methods of implementation were determined.

RECOMMENDATIONS

The speech and language program should be continued with more indepth diagnostics and therapy performed on certain children already in the program. Most certainly this same consideration should be given to all incoming children. It is imperative that the needed supplies be purchased for the speech program.

In view of resources available in this area consideration might be given to greater utilization of the staff and facilities at the Center for Audiology and Speech Pathology.

BRAZOSPORT SPEECH & HEARING SERVICES, INC.

Speech Pathologists

Ervina Anderson, M.A.
Norah Thurman, M.A.

(713) 297-1188

135 OYSTER CREEK DRIVE - SUITE D
P. O. BOX 539
LAKE JACKSON, TEXAS 77566

SPEECH, HEARING AND LANGUAGE SERVICES PROVIDED TO ANGLETON AND FREEPORT HEAD START CENTERS AND HOME BASE PROGRAM AT ANGLETON

END OF YEAR REPORT

In 1977, through funding of the Gulf Coast Consortium, the Head Start Program in Brazoria County was able to offer to the children the Speech, Hearing and Language Development services through Brazosport Speech and Hearing Services, Inc. Brazosport Speech and Hearing Services, Inc. is a recently formed private enterprise, composed of two speech pathologists which is providing the much needed services to the children in the Brazosport area. This corporation is centrally located and is easily accessible to both the Angleton and Freeport Head Start Centers.

The paramount purpose of speech and language services in Head Start is to give each child a head start in oral communication skills. In order to determine the needs of each child, an informal assessment of speech and language skills is administered and plans are formulated for specialized therapy or further formal assessment of speech and language skills.

We believe that effective communication is a prime concern in assuring a child a head start in education. A child who exhibits a communication disorder is indeed handicapped. There are three major processes that must occur before effective communication can evolve:

1) reception of stimuli; 2) integration of stimuli and; 3) expression of that stimuli. Therefore, in order for a child to communicate properly, he must be able to receive audio and visual stimuli, integrate that stimuli in a meaningful manner, and then express his ideas adequately in one of the areas of communication. When there is a breakdown in any of the processes; i.e. reception, integration, expression, then there is also a breakdown in the speech or communication chain.

Most of the children in the Head Start Program are unable to express their ideas, needs, or desires adequately due to a lack of communication-enhancing stimuli in their environments. Head Start Programs are designed to provide stimuli for the children and to help unfold the potential for learning in each child. Parents should also be encouraged to become involved in the learning process with their children, and at the same time, provide opportunities for the parents themselves to develop their own potential. Our opinion is that parents should be more actively involved in the Head Start Program.

This year speech and language services were provided for the children at the Head Start Centers. Included in the services were speech and language screenings and direct therapy at both the Angleton and Freeport Head Start Centers. Pure-tone audiometric screenings were administered to the children at the Freeport Head Start Center. At the close of the school year, pure-tone audiometric screenings were requested by the directors of the Angleton Head Start Center and Home Base Program for those children still in need of a hearing evaluation.

A total of 137 children were seen for the initial speech and language screenings. These totals are inclusive of both centers and the Home Base Program in Angleton. From the original total of children screened, 14 in Angleton and Home Base, and 13 in Freeport were determined to be in need of speech and/or language therapy. Sixteen children exhibited vocal characteristics of a voice disorder and were referred to physicians for laryngeal examinations. Nine children were found to be in need of formal assessment in receptive and oral expressive language. These children and additional children were formally evaluated in May 1977.

Ethnic environment was not the primary determinant in placing a child in speech and/or language therapy. However, they were placed in therapy, if needed, as a result of their performance during the initial speech and language screening phase. Twenty-two children who exhibited articulation problems of a transitory nature were observed during the period March - May 1977. When children enrolled in the Centers after the initial screening process, enrollment in therapy or formal follow-up diagnostic test evaluations were determined. Copies of all reports were forwarded to the appropriate administrative personnel. The services were provided at the Centers instead of the Brazosport Speech and Hearing Services office because we felt the children would respond more effectively in a familiar environment. There was a tremendous amount of cooperation from the directors and teachers in helping us achieve this goal.

The results were very rewarding in that the children accepted us as a part of their environment and cooperated enthusiastically. Considering the short length of the therapy program (three months), progress was remarkable. As funding for next year will be full year, the therapy program, staff and parent in-service programs should yield dramatic results. The thrust of the program was in providing the services to the children. Next year in addition to working with the children, the emphasis will be on transmitting actual speech and language therapy procedures to the directors, teachers, aides, and parents.

Follow-up diagnostics were administered in our office by appointment. The center directors brought the children to the office where receptive and expressive areas of oral language were evaluated. The results indicated that all ten of the children evaluated in depth were deficient in both areas with the most significant lag in the oral expressive area of language. The results of the individual evaluations were reported to the directors, teachers, parents, and the Coordinator of Special Services. Recommendations for helping alleviate the child's specific problem were given to the teachers *and* to the parents.

At the end of the year, and as a preface to the more extensive staff and parent involvement, a workshop was held for both centers focusing on Speech and Language: Oral Communication. At this time, the teachers were given an overview of the intricacies involved in the process of learning language. The three processes of reception, integration and expression were also discussed. A brief description of tests used in formal diagnostics was presented to the staff members. The primary purpose of the workshop was to impart skills to help the teachers identify children (who will be in the program next year) who might have a communication disorder. Their observations and recommendations will become of greater value in helping implement a program of facilitation for each particular child.

Recommendations for 1977-78 school year:

1) Speech, Hearing and Language services should be extended to include the entire school year. This school year our services to these children covered February - May of this calendar year.

2) Continued initial meetings with parents, Head Start staff concerning each child's speech, language and/or hearing disorder based on the findings of initial screenings.

3) Additional involvement with center directors, staff and parents concerning explanation of actual speech and language therapy procedures.

4) Staffings between Brazosport Speech and Hearing Services, Inc., Head Start personnel, and associated agencies serving the children when deemed necessary for the best interest of the children.

5) Direct communication between Brazosport Speech and Hearing Services, Inc., and University of Houston Psychology Department. Maintenance of cooperation between Brazosport Speech and Hearing Services, Inc., and Family Service Center in Lake Jackson. A paramount concern is the elimination of duplication of testing.

6) Continued workshops presented by Brazosport Speech and Hearing Services, Inc. Speech Pathologists to Head Start Centers' personnel.

7) Initiate parent workshops to enhance the home carry-over program in speech and language therapy.

8) Maintenance of the supportive working relationship between Brazosport Speech and Hearing Services, Inc. and the Coordinator of Special Services of Gulf Coast Community Services Association, Coordinator of Head Start Programs in Brazoria County, Director of Head Start Program in the Brazosport Independent School District and Center Directors.

E. Anderson

Ervina Anderson, M.A.
Speech Pathologist

Norah Thurman, M.A.
Speech Pathologist

July, 1977

BRAZOSPORT SPEECH & HEARING SERVICES, INC.

Speech Pathologists

Ervina Anderson, M.A.
Norah Thurman, M.A.

(713) 297-1188

135 OYSTER CREEK DRIVE · SUITE D
P. O. BOX 539
LAKE JACKSON, TEXAS 77566

June 27, 1977

Gulf Coast Community Services Association
6300 Bowling Green
Houston, Texas 77021

Attn: Dr. George Wawrykow

Re: Follow-up Diagnostics

ORAL LANGUAGE - RECEPTIVE AND EXPRESSIVE

Children were not given follow-up diagnostics nor follow-up therapy where English as a second language was the major oral communication difficulty for the child; Mex-Tex and black dialect we consider to be parallel or equal languages to the white middle-class English language; therefore, only those children who demonstrated receptive and/or expressive communication handicaps apart from the ESL or black dialect were those included in the follow-up services.

All of the children on whom follow-up diagnostics were administered are classified into two categories: 1) those with an oral communication difficulty and those with communication difficulties, which, if left unattended would present definite handicapping conditions upon entrance into public school and, 2) those children whose oral communication difficulties were diagnosed to be developmentally transient in nature and required no intervention.

FOLLOW-UP DIAGNOSTICS

We are adamant that since accurate diagnosis of the pre-school child is very difficult due to lability of feelings, varied success in entering and forming new relationships, the wide range of dependence/independence, etc., that formal diagnosis be administered only after the above have been completed. This is an endorsement of the Gulf Coast Consortium Policy of formulating formal diagnosis only after extensive observation and intervention has been completed. Thus, initially, our informal or functional diagnosis was formulated. This, of course, was modified and changed as our understanding of the child and his problems or the converse - his needs were better understood. The formalized recommendations represent the total picture of the child and are based on informally implemented recommendations which followed from the functional diagnosis.

Ervina Anderson

Norah Thurman

ADMINISTRATION

# of Handicapped Programs

and the

SOCIO-CULTURAL IMPACT

# of these programs

SOUTH PARK ISD - HEAD START MAY 5, 1977

ADMINISTERING HEAD START FOR HANDICAPPED

In June, 1976, after the initial dissemination of information that funds were available to serve handicapped children, numerous local contacts were made by phone and personal conferences with school district personnel and private Consultants to determine local services. After Special Education personnel in South Park ISD concurred that staff would not be available for Head Start, agreements were made on a tentative basis with Speech Therapists and a University Professor (Early Childhood - Special Education). Psychological services would be increased because of this new grant.

Two consortium meetings were held in Houston to "brainstorm" and finally submit proposals. Although the PY date was August 1, 1976, funds were not received by the consortium until November and the Grantee obtained the check for Flow-through funds in December, but did not release to delegate until January, 1977.

Speech Therapists screened in January, - provided in-service to help teachers and immediately began therapy with resource teacher (developmental assistant - Level III) to follow-up activities.

Professor was unable to report until February due to other commitments. Diagnosis and follow up centered around children who had passed speech screening, but who needed intervention and remediation, according to teacher and psychologist.

Administratively much time is spent in consultation with teachers and consultants. Director gives psychologist a list of children's names and problem areas at each visit. He briefly reviews with director the total situation, then confers one-to-one with each teacher to give supportive services, suggested techniques and to observe children in the group setting.

Director followed-up on speech therapy candidates, and referrals to early childhood consultant as to progress of diagnosis and follow-up. Statistics are necessary for quarterly report. Once a week joint staffings are held. Handicapped Coordinator has been invaluable in implementing the grant, and advising in areas of concern. The additional time and paper work was endured because of the tremendous benefit to the children.

The regular program is in dire need of Resource personnel to serve about 1/3 of the children who need extra help but are borderline, and should not be labeled handicapped. A teacher cannot attend on a one-to-one to all the children who need extra help.

Volunteer time is not easy to obtain. It seems unfair to expect local programs to tap community resources, asking to donate time. Since Head Start began in 1965, the economy has changed and is now such that donated time of value is "hard to come by." One consultant stated that she felt it was unethical to ask to donate 20% and only get paid for 80% of time involved.
Head Start provides funding for studies by many consultant firms that are not as helpful for local program implementation.

Although professional staff in our Head Start program are degreed, financial compensation is inappropriate when compared to local school district personnel.

Handicapped Funds

South Park ISD

Use of Developmental Assistant

Exceptional children have many unique needs, which to be met adequately, demand individual attention. To facilitate individualization, additional part time staff were employed to assist in the classroom with personal care, motor room activities and meal service, depending on the extent of the child's limitations. Four high school students rotated among six classrooms to relieve the teacher in regular activities to enable the teacher to devote time to small group or individual learning experiences with identified handicapped students. Teachers made separate lesson plans and also indicated on regular weekly plans, their specialized activities. Maximum benefit depended to a great extent on the ability of the high school student to handle the Head Start routine with minimum supervision.

A fifth developmental assistant was a graduate student, certified in Special Education, with early childhood training and experience teaching in special education and pre-school. She formulated activities in language and concept development for children identified by Speech therapist, and early childhood consultant. She was also able to administer Peabody Picture Vocabulary Test, Denver Developmental Test, Draw-a-Man to aid in diagnosis.

Teachers agreed that the Graduate Assistant and Speech Therapist giving individual and small group attention to handicapped children made a tremendous impact on the children's skills, later demonstrated in mainstream events.

Funds are needed additionally for resource help for students who may not qualify for handicapped label, but who are so borderline that they need special techniques to develop to the minimal level of success.

Focus: Graduate Assistant (Resource Teacher):

1) Liaison between consultants and teachers -

2) Individual and classroom observation and instruction -

3) Aid in evaluation of planned instruction and its implementation in the classroom.

Claire Collier
5/4/77

Goals for 1977-78 include:

1) Staff conference with receiving Kindergarten teacher in July, 1977 for borderline children.

2) Refer to Special Education for screening with parent consent on five (5) children.

3) Set up a screening plan for all students in October, 1977 using for example PPVT, VMI to enable teacher to obtain an early view of deficit and strength areas.

4) Develop simple forms to write plans for case folders with a minimum of paper work. (Some very competent consultants will not assist if they are bound to do lengthy reports - especially if they are donating part of their time).

Claire Collier
5/5/77

HELPING THE HANDICAPPED: DEVELOPMENTAL ASSISTANT

Under a grant extended to the Head Start program of the South Park Independent School District, new personnel were added to the program to provide services to handicapped children. The position of Developmental Assistant was developed by the guidelines established for use of grant funds.

The rationale for the new position is that the "utilization of a Developmental Assistant and/or Aide Trainee will enable teachers to provide more effective individualized instruction to children assessed as in need of specialized learning."

The Developmental Assistant position is broken down into three levels. Level I is also called a Teacher Aide Trainee, with preference for this level to be given to VOE and VAC students. The duties of the Level I Developmental Assistant are to assist in the classroom in any way so as to replace the teacher or aide, who would utilize the freed time to work with handicapped children on an individual or small group basis. The Level I position will open new career opportunities to VOE and VAC students exhibiting competence and interest in training in child care and working in Early Childhood Education.

The Level II Developmental Assistant would be a college student with Special Education and/or Early Childhood Education training. The Level III Developmental Assistant would be a graduate student with S pecial Education and/or Early Childhood Education training. The goal of the Level II and III Developmental Assistant is to develop resources to provide or arrange services for handicapped children.

The Level II and III Developmental Assistants may have many varied duties in working with handicapped children. First of all, the Developmental Assistant II and III could serve as a liaison between the classroom teachers and the program consultants, such as the Speech Therapist, Special Education - Early Childhood Consultant, etc. The Developmental Assistant can spend time needed for concise communication. Not only will the Developmental Assistant serve as a liaison, but she will also play an important role in individual and classroom observation and instruction. The Developmental Assistant will be able to input to the total picture of the handicapped child by working with the children individually, and also by making careful observation of his work and interaction in the classroom.

This observation can be used by the consultants in developing designed programs of instruction for the individual children. The Developmental Assistant may also take the responsibility of observing the implementation of the designed programs within the classroom, and may, with the teacher's help, evaluate the effects of the program on the individual child.

The Developmental Assistant will have as her responsibility individual instruction periods, in which she will work on problems identified for the handicapped child by the consultants. She will use materials suggested by consultants after careful examination of the contents. She should also take the initiative to become familiar with the teaching aides and materials available at the school, and use these materials, where applicable, in her work with individual children. The Developmental Assistant may also use this working knowledge of available materials to help classroom teachers locate specific materials needed by them for use with the total group, as well as with the identified children.

The Developmental Assistant may also want to take the initiative in helping in the development of learning activities, or games, to supplement instructional plans used by both her and the classroom teachers.

Record-keeping will be another area that the Developmental Assistant will want to use to its optimum. As was mentioned earlier, the Developmental Assistant can aid tremendously in the evaluation of handicapped children by using classroom observation, and an accurate record of these observations will be invaluable for use in planning sessions. This record should include the child's relationship to the other children and teachers; how independently he works; and what approaches to instructing this child the teacher makes; to name a few general areas.

The Developmental Assistant would also need to be responsible for collecting, dating, and filing in the child's cumulative record classroom work examples for each child under consideration. The regular collection of examples will help in the assessment of the child's developmental progress.

Not as a requirement, but for the benefit of herself, it is suggested that the Developmental Assistant keep a personal record. This record may include the recordings of specific activities used with the children, as well as comments on feelings of success or failure. The Developmental Assistant would want to jot down any ideas she might have, as well as questions or observations she feels she would like to discuss.

In order for the Developmental Assistant to best analyze her achievements and techniques, she would meet with the Program Director on a regular basis.

In these meetings the Program Director would evaluate the Developmental Assistant's work, as well as offer constructive criticisms and suggestions for the future.

The Developmental Assistant will also need to meet in regularly scheduled conference times with the consultants to learn what determinations have been made concerning the children, to discuss and evaluate planned instruction approaches for the individual child, and to add whatever input she has collected in her observations and work periods.

The Developmental Assistant may also be utilized in the planning and execution of in-service programs for teachers, teachers' aides, Developmental Assistants-Level I, and parents. She should also participate in any in-service programs offered or required, for the improvements of skills and techniques in instruction and observation.

The Developmental Assistant will be extremely helpful during the screening of children, in that she may administer such tests as the Peabody Picture Vocabulary Test, the Denver Developmental Screening Test, and any other testing materials assigned by the consultants. This testing responsibility has a two-fold purpose: 1) the addition of pertinent information to the child's cumulative record, and 2) the release of time required by the tests for the consultants to do other, more indepth, testing procedures.

Finally, the Developmental Assistant may be an invaluable asset to the classroom teacher. Not only is she a communication line between the teachers and consultants, but she also may be used to demonstrate in the classroom specific techniques or skills prescribed by the consultants for individual teachers. In addition, she may play a valuable role in the encouragement of teachers' successes in using prescribed programs, as well as conveying to the teachers the idea of their importance as vital and equally-contributing members of the total team.

The Developmental Assistant II and III may be a wearer of many hats - being responsible in many areas, including the classroom, in individual instruction, and in the consultation room. Although there is provision for either a graduate student or undergraduate student, it would seem likely that in most cases the graduate student would be preferable.

The graduate student may have had some teaching experience, either in a full - or part-time, or substitute capacity. She will also have had student teaching, and in all probability will have had more classroom observation hours. While this experience does not guarantee the graduate student will be better equipped for this position, it is likely she would more easily move into the program with little specific directions. Some other advantages a graduate student may have over an undergraduate student would be more hours in classroom study of Special Education and/or Early Childhood; some previous experience or exposure to testing procedures; and more familiarity with teaching materials, activities, and procedures used in the planning of individual instruction.

Although the Developmental Assistant may range in abilities from the VOE, VAC student to the graduate student with teaching experience, it is obvious that Developmental Assistant will be most beneficial to the Head Start Program. Through the use of these personnel, handicapped children will receive more intensive and higher quality instruction than was possible in the past.

Marlynn Rumm
Graduate Student, Lamar U.
South Park ISD - Head Start
Developmental Assistant - Level III

Level III Developmental Assistant in essence is a Resource Teacher to meet the unique needs of handicapped children. A part time experienced teacher with Early Children background could serve in this capacity.

(Mrs.) Claire Collier, Director

CENTRAL DAY CARE ASSOCIATION HEAD START HANDICAPPED SERVICES

(Final Report on Program and Consultation Services)

This is a progress report on the contracted consultation services and provision of special needs for the handicapped children in programs of Central Day Care Association. The handicapped program is administered according to the education program and health program guidelins as stipulated by the HEW Office of Child Development.

The objectives of the handicapped program are as follows:

1. Early identification of the handicapped child.
2. To provide educational experiences for the handicapped child.
3. To promote the psychosocial well-being of the handicapped child.
4. To help the parent increase their understanding of the child and promote parent involvement.
5. To increase the staffs' basic skills in the areas of early identification and educational planning.
6. To increase the staffs' understanding of handicapping conditions.
7. To increase the staffs' and parents' knowledge of resources and services available to these children and their families.
8. To provide the staff with professional consultation.

Children who are enrolled in the program and who receive the special services offerred children with handicapping conditions are diagnostically grouped in two categories: 1) Those children who have been formally identified and diagnosed as haveing a handicapping condition and 2) Those children suspected of having a handicapping condition who are in the process of evaluation. Children in these two categories come from various referral sources. The two most frequent sources are: 1) Those children presently enrolled in Head Start that have been observed by a staff member of consultant (nursing, nutrition, speech and hearing, mental health, education) to have difficulties and in need of evaluation and 2) Those children who have been formally evaluated and diagnosed by a professional outside the program and who are referred to the program. Children are also referred by parents and community agencies who suspect that they have some difficulty and are in need of evaluation and services.

Children who are presently enrolled in a Head Start Center and who are observed to have some difficulty are referred to the Center Director.

The child is then staffed by a team consisting of the Center Director, the teacher, and the appropriate consultant. All availabe information on the child is reviewed and a plan of action is decided upon. The parent is contacted to obtain any additional information deemed necessary and to share the recommendations of the team. The recommendations and courses of action very depending upon the mutual concern and the presenting problem. They may include: 1) Additional Information, 2) Diagnostic evaluation, 3) Educational planning, or 4) psychosocial interventions. If a child is referred for an evaluation other than a medical evaluation, the child is first screened medically to rule out the possibility of medical complications.

If a child is diagnosed as having a handicapping condition, the child's strengths and weaknesses are outlined, classroom objectives are outlined, and related activities such as follow-up and parent involvement are outlined. All information regarding the diagnosis, recommendations, referrals, and follow-up procedures is recorded in the child's administrative folder.

The majority of children in this program fall in the categories of Speech Impairment and Health Impairment. The Speech Impairment category (does not include bilingual) appears to be overloaded because some learning and developmental difficulties have been included.

Records which include descriptive information on the categories and numbers of children in the categories are kept in the Central Office as well as in each Center. A master file is kept in each Center which contains health information on all children in the Center. This master file serves as a ready reference for the health status of all children in the total Head Start program. All children upon entering a Head Start Center have a medical screening and an annal assessment which includes medical, vision, hearing, dental, nutrition, and developmental screening. All screening completed and needed to be done is recorded on this master file.

Resources available to the staff, children and parents are the Health Services Advisory Committee, consultants in the areas of pediatric nursing, pediatric medicine, nursing, mental health, nutrition, speech and hearing, education, community agencies, the Galveston Independent School District, and the University of Texas Medical Branch. The Health Services Advisory Committee meets regularly with the Executive Director, the Educational Supervisor, and the Center Directors to advise and assist in the planning and implementation of all aspects of the halth programs including the ahndicapped program. Members of the Committee and the consultants to the handicapped program are available for case conferences on those children who are being considered for enrollment in the program and for those children in the program.

Funding from the Gulf Coast Community Services Association and the consultation of Dr. George Kawrykow have greatly increased the effectiveness of the handicapped program. One of the most valuable benefits was the support of the mental health, speech and hearing, and special education consultants. The mental health consultants offerred case consultation and program consultation as well as educational programs for both staff and parents. The speech and hearing consultant offerred diagnostic and remediation services, and the special education was responsible for assisting in the overall program. Activities of the special education consultant consisted of planning, implementation, mobilizing community resources, consulting with the staff and other consultants and coordination of the overall program. This required close work with the Executive Director and the Educational Supervisor as well as the Health Services Advisory Committee.

It is felt that the majority of the objectives of the program for handicapped children were met during this past year. It is felt that all of the activities of the previous year were beneficial to the staff, children and parents of the Head Start Centers. It is recommended that in the coming year emphasis be placed on further strengthening the support and resources available to the families of these children in their communities. There are still additional supports availabe to these families in the community that need to be identified so that they can be linked with these support systems (both tangible and intangible supports).

CENTRAL DAY CARE ASSOCIATION: HEALTH SERVICES OBJECTIVES, POLICIES AND PROCEDURES

The Central Day Care Association aims toward the goals and objectives set forth in the Head Start Program Performance Standars. The overall philosophy toward health care and services is to provide a program which provides for quality care, continuity of care, health education for staff, children, and parents, and any other special needs of the children and their families. The program utilizes a variety of resources for services, education and consultation. The following represent some of the resources: Health Services Advisory Committee, Galveston County Health District, University of Texas Medical Branch, Galveston Independent School District, private health practitioners, College of the Mainland, and County and State Welfare programs.

The Health Services Advisory Committee consults with the Central Day Care Association on the health services program, providing administrative, program and case consultation. The primary function of the committee is to serve in an advisory role in regards to the planning, operation, and evaluation of the overall health services program as well as providing coordination of services and service providers. The committee meets monthly with the Executive Director, the Educational Supervisor, and a representive from each center (usually the Center Director). Membership of the committee includes one or more of the following: mental health professional, social worker, public health or pediatric nurse, pediatrition, nutritionist, early childhood educational specialist, health administrator and parent.

A health record is opened on each child at the time of enrollement in the center. At this time a medical, dental, developmental and social history is recorded. The child is also seen for a physical examination. The screening shall include (1) growth assessment, (2) vision, (3) hearing, (4) hemoglobin, (5) tuberculin, (6) urinalysis, (7) sickle cell and lead poisoning, (8) immunization status, (9) speech, and (10) any physical or mentally or socially handicapping condition as well as nutrition, and dental. Annual screening to be done as near the beginning of the school year as possilbe shall include items (1), (2), (3), (4), (5), (8), (9), and (10). Parents shall be kept abreast of all of the above and encouraged to participate. Staff, children and parents shall be involved in health education through all of the above activities as well as through planned educational activities.

In order to assure better care and continuity of care the Center Directors will be the persons who will be ultimately responsible for the health services program in each center. It will be the Center Directors" responsibility to work with the staff and the consultants in the planning and implementation of the program. An important aspect of the above is the policies and procedures which should be followed in regards to the disposition of children who are suspected and/or identified as needing the services of health providers and/or other specialists in the community. Children in need of any of these services are usually identified in one of the following ways: (1) formal screening, (2) parents interviews, (3) teacher observations and (4) health professional and consultant observations. All children identifies should be brought to the attention of the Center Director by the person making the identification. If this person is not the classroom teacher, the classsroom teacher should be informed as soon as possible.

The Center Director has the responsibility of seeing that the following policies and procedures are complied with on all cases brought to her attention:

1) The child's health record shall include for each suspected problem, a statement of the problem, diagnosis, plan of action, recommendations, and follow-up.

2) If the plan requires referral to a health care provider or other community resource, referral should be coordinated by the Center Director (or person so disignated). A conference should be held with the parents and all pertinent information (with the consent of the parents) should be made available to the professional or agency that the parent has agreed can evaluate their child. Parents are to be encouraged to accompany their child to the evaluation (treatment, follow-up). A report of the professional or agency finding and recommendations should be requested. The information should be made available to the persons in the Center who will be working with the child. The recommendations and results should be discussed with the parents to make sure they understand and that communication channels are open.

3) The assessment and identification of handicapped children shall follow the guidelines established by the Office of Child Development "Diagnostic Criteria for Handicapped Children."

4) A Master Log shall be maintained at each Center to help facilitate and coordinate the providing of health services to all children.

5) Health records of children in the program shall be reviewed periodically by the Center Director, Executive Director, Educational Supervisor, or members of the Health Services Advisory Committee/

Even though the Center Director is ultimately responsible for all of the above, it is suggested that she collaborate with the consultants so as to help insure coordination and continuity of care. The following are recommended as initial routine courses of actions: 1) Any suspected medical problem shall be referred to the Nurse, 2) Any suspected speech, language, or hearing problem shll be referred to the speech consultant, 3) Any suspected behavior, developmental, family, or learning problem shall be referred to the social work of mental health consultant, 4) Any suspected nutritional problem shall be referred to the nutrition consultant. These are guidelines and it is understood that sources of referral vary at times.

As part of staff development as well as further assuring of continuity and coordination a mental health consultant will be availabe to meet with the Center Director and Staff of each Center, preferrably once a weekso that any problem whatever its dimensions may be discusses.

Selected Professional and Socio-Cultural Effects of the "Handicapped" Services Project On the Alabama-Coushatta Indian Reservation Head Start Program

BY: Catherine L. Swearingen

MAY, 1977

The Alabama-Coushatta Indian Reservation Head Start Program centers its focus upon the background and the culture of the Indian Children and their ancestors, as well as upon developing social skills. A third major emphasis is placed upon language development.

Therefore, when the work of the Gulf Coast Consortium was in the formative stage, we on the Reservation desired a "Handicapped" program design that would incorporate all of our philosophies of Early Childhood Education, as well as including some means of facilitating an on-going reinforcement of the Indian culture and attitudes. Our strategies incorporated educational principles, the Head Start Performance Standards, the utilization of sundry community resources, parent and staff training, mainstreaming and the meeting of individual needs.

Our Consortium's emphases correlated with our local objectives. One emphasis was "the developmental unfolding of each child in Head Start, regardless of his or her handicapping condition(s)". One would quickly corroborate that a child's "developmental unfolding" would include postulating assertion and progress of development in the following domains: physical, intellectual, emotional and spiritual.

Consequently, the planning stage involved careful study and research. As a result, much of the organizational labor resulted in a learning experience for me, professionally. One interesting example of my gain was derived from our Consortium's decision to modify the order of diagnosing the children. Whereas, many professionals choose to first spend a great deal of time writing a formal diagnosis and later writing a functional diagnosis, our consortium chose to conduct our assessments differently. Those of us who are participating in our Consortium are first writing a functional diagnosis; then, a formal diagnosis is given. We also chose to Conduct Screeening, Assessment and Diagnosis Concurrently and not Consecutively. The interim direction, progress and problems that have been facilitated since the initial planning stage have been opportunities for my professional growth, as well.

Undeniably, there are an endless number of supportive examples and anecdotes that would be appropirate in this regard. In the following paragraphs, I shall briefly share some of them in the hope that it may be of benefit to any readers in there own programs and in order to give them some insight into the program design of the Alabama-Coushatta Indian Reservation Head Start services to the "Handicapped".

One would immediately concur that a child should receive a reconnaissance type examination before any diagnosis regarding a handicap can be ascertained. I definitely feel, then, that we were fortunate to work in conjuction with the Department of Pediatrics Child Development Division of John Sealy Hospital in Galveston, Texas. (Univeristy of Texas Medical Branch) By working in conjuction with them, we were able to conduct a thorough medical screening for all of our children at a two-day "clinic" that was performed at our own school site. To render the screening, numerous professionals and specialists came to our Center: pediatricians, an audiologist , medical residents, a physician's assistant, and a social worker, and at a later date, a nutritionist. Consequently, our objective that was stated in the beginning of this article, focusing on the inherent features of our local community, was fulfilled; surely, then, we were extremely grateful that the Child Development Services "came to our home field!"

Another institution with whom we have worked is Lamar University of Beaumont, Texas. Two departments from Lamar incorporated working with our children into curricula for their masters programs; the two departments to which I have referred were the Speech and Hearing Clinic and the Department of Psychology. Needless to say, the influx of all of these new people, with their specialized training, expertise and skills have had a tremendous impact on my professional repertoire. In turn, our entire Staff has benefitted in several areas, including new enthusiasm, new approaches, new ideas and new methods.

Refurbishing already internalized philosophies always enhances professionalism, as does exposure to new concepts and materials. I believe that we have benefitted the graduate students, as well. These University students have been participants in socio-cultural-educational field experiences. The children have also benefitted tremendously. For instance, many of our children who had previously been hesitant and timid with new adults were actually volunteering to participate in activities with the speech therapists and psychologists in some of the very first, informal visits. Needless to say, I was shocked, but elated!

I personally believe that our program has benefitted the Lamar University and Univerity of Texas students as richly as we on the Reservation have benefitted from working with them. Hopefully, we have gained mutual professional respect and greater understanding of other skills, attitudes, vocabulary, techniques and environments. I cite, for example, the Indian practice of employing "learning centers" within the the home, long before early childhood professionals employed them. As many young children develop in some Alabama-Coushatta Indian homes still today, they are allowed to explore more areas in the home and they are allowed to touch, to see, to feed, to smell and to listen. These permissive early childhood experience in homes that still indulge them often result in greater independence and greater ability for reasoning and decision making.

Another way in which I feel that we have been influential in the field experience of these professionals is also derived from a socio-cultural domain. We on our Reservation Head Start Staff have attempted to expand the Old Indian practice of developing independence and to integrate other beginnings of modern social conduct and social skills, as well. So, at the very time that I am writing this article one of our children is probably very proud of himself for taking initiative in Classroom activities, or for kindly saying, "please" or "thank you," or for lending a helping hand to an injured child on the playground. We have attempted to work with -- and not against-- our parents to promote a consistent pattern for our children. Furthermore, the agencies with whom we have worked have been cooperative and supportive in meeting individual needs and interests of the "handicapped" children, so that consistent models are not impeded.

Indeed the personalities and activities of these professionals have been perfectly suited to our particular Center: they work well with our children, collectively; and they work tremendously with our children, individually. (Hence, mainstreaming has been smooth and effective!) One teacher wasespecially appreciated the manner in which the professionals have "persevered" with screening, assessment and diagnosis -- in order to overcome language and communication barriers and in order to enhance the Indian culture. I was especially impressed by the therapists' obvious willingness to cooperate with other professionals with whom we are associated. All transactions are carried out in an efficient, pleasant way, so that the surroundings are not "clinical" rather, they are a desirable, informative, "happy" learning time for us all!

There are an endless array of reasons to substantiate my following assertion: the nicest facet of all the "Handicapped" Consortium program has been that ALL OF THE SERVICES HAVE BEEN BROUGHT TO US. From the many reasons, I have selected three to enumnerate: (1) The young children so not have to travel long distances to receive services; (2) A rapport between the Head Start children and the professionals can be established within a territory that is already secure and familiar to the children; and, (3) The professionals gain a better understanding of the local community, thus ENABLING them to become involved more extensively with parents and the Head Start Staff.

The second most important facet of the overall "Handicapped" Program, in my opinion, has been the general assistance with assessing the Head Start students. Many of the diagnoses were ones thatI had expected; many others were enlightening. PRACTICALLY ALL OF THEM WERE VALID, after I examined the children and the specific areas more carefully. The significance of all the assessments has been that all have been conducted with impact from parents, with staff or from some other agency.

A third significant facet of the "results" of our Alabama-Coushatta Indian Reservation Head Start Services to the "Handicapped" has been the considerable emphasis upon strong Language Development, as coincides with the objective to which I eluded in my introductory paragraph. The title of my article indicates that the numerous services to the Indian children in our community have had some effect, as I have explained; the majority of the effects have been positive ones, as is the case in the area of Language Development. The Reservation Head Start Staff emphasizes the importance of verbal communication in the Indian language and in the English language. Naturally, since the children will enter first grade in the public school, we do use English in the classrooms here. (Note: Over one-half of the Staff members are bi-lingual Indians, further we have regularly - scheduled Indian dance lessons and numerous other emphases on the Indian heritage that perpetuate Indian vocabulary). It was discovered by the Lamar University Speech and Hearing Clinic that only one child actually had a bona fide articulation problem; the other students with whom they work need to develop stronger language and communication skills, primarily. Many kits, materials and activities were employed -- and enjoyed by the children. In fact, most of the children were eager to "take turns having fun learning".

I think that it is vital that I interject one piece of theory regarding the need for extra emphasis on language. One would agree that handicapped children have a break down in one or more of the following processes: input (auditory, visual, tactile,olfactory, taste, "sensory"); association (neo cortex, old brain, kinesthetic); or output (verbal or non-verbal responses). Our children were successful in the input and often in the association process, generally speaking. However, they had difficulty using either: (1) English symbols; or (2) verbal expressions and responses. To help remediate these difficulties, activities centered around developing language skills, such as vocabulary developments, sentence structure, reading readiness skills, (i.e., Colors, shapes), and pronouns. Readers might be interested in my mentioning that in the Alabama-Coushatta Indian dialects, there are no words to differentiate gender nor pronouns. Also these Indian sentence patterns are essentially devoid of superfluity and there are no written language symbols. I should also mention that the syntax is different. Generally speaking, the children gained greater ease with oral communication by having participated in the Lamar University language classes.

Audiologists in the aforementioned Speech and Hearing Clinic discovered three children who severely needed medical attention for hearing problems. On the initial screening it had appeared that the number would be far greater. The in-depth assessments revealed that the children's responses were better because the Head Start students because were more familiar with the testers at that point. One of the students, a darling yound Indian girl was in the urgent need of a myringotomy and adenoidectomy, which she received immediately. Had she not had the surgery, it was suggested that she could quite possibly have been "handicapped" even in adulthood by a permanent hearing loss. Her hearing loss could have hindered her learning and would have obstructed her comprehensive "developmental unfolding". To say that it was gratifying to see her poor hearing condition virtually erased would sound somewhat like a platitude; but, that is not my intention in so writing.

Someone once said, "After the rain, the Rainbow". In the case of the marvelous results after the young girl's surgery, I encountered, "the rainbow", figuretively - speaking; In many other instances, however, I encountered "the rain". All programs, including our "Handicapped" Services effort, have an inherent barrage of problems and their own breed of negativism.

.One of our most overwhelming porblems has been our lack of a full-time director
to coordinate Head Start's Education, Health, Nutrition, Social Services and Parent
Involvement Components for us, locally. With the Head Start "Handicapped" Grant came
a fully equipped volume of paperwork, thereby adding to our need for a full-time ad-
ministrator. To make matters worse, I became frustrated frequently from my consequen-
tial absence from my own classroom and I occasionally would resent the almost consum-
ing demand and aggravations that I incurred. If I had thought that the last of our
problems was our being under-staffed originally, I had yet to experience the resigning
of the Development Assistant. The capable, interested Indian lady, whom I had only
finished training to work with some specific developmental needs, had to regretfully
resign because of ill health. In conclusion, we have no secretary to keep abreast or
clerical work. To return to a positive vain I once again acclaim the adage, "Every
cloud has a silver lining!'' Saying that my own professional comprehension and judg-
ment have been increased would merely be one "siler lining". Even adding that an on-
going self-evaluation has made me reflect loyalties or objectives in my working with
the Alabama-Coushatta Indian children on the Reservation would by insufficient. I
have found many other "silver linings": I have gained a fondness, a determination and
a greater love for the children and their families; I have had to develop greater ad-
ministrative and training skills, I have learned to grasp for patience. I have in-
creased my respect for the vital need for developing new attitudes and skills for
"handicapped" children within the Community; I have acquired novel lnowledge; and
I have reminded myself that I shall stagnate, professionally speaking, unless I expand
upon this beginning, minimal framework of study and research.

Still other challenging, exciting, innovative "silver linings" are presently
planned for the up-coming months. This summer, the therapists plan to take local field
trips -- perhaps to the Sundown Amphitheatre, to the pottery factory, to the Indian
ance arena, to the Living Indian Village with its model woodland home, arrowheads, fry-
read, beading and basketry or to any place that would accomodate the professionals'
ork with the children. Next year, we hope to make an even more Effective Early Child-
ood Resource Development Program on the Reservation. This year our local emphasis,
ike that of the Gulf Coast Consortium, was on mobilizing resources and brining them to
he Reservation. However, realizing that a successful "Handicapped" Services effort
equires effective organization, effective programs and effective people, we hope to
ake our In-Service enphases center upon: language experience for handicapped children
hat can be conducted by both parents and teachers, the three processes which create
isabilities; how to help children's creativity or related to those processes; and
rimarily our staff's acquiring greater skills in writing functional diagnoses and
ducational plans for handicapped children. Lastly, we are eager to continue follow-
p services on a regular basis. Our remote propinquity facilitates a large amount of
xpenses involved with follow-up services. Until the recent "Head Start "Handicapped"
rant was awarded, most follow-up services were minimal, distant, inconvenient and in-
ppropriate. The Reservation locale is lovely and fecund. However, there is a limited
mount of professional services available in this immediate area. We are encouraged
y the extensive follow-up services that we have experienced during the past few months;
nd I personally feel that we shall be fortunate enough to see them continued in the
ture.

I shall, then, conclude by giving a summation some selected socio-cultural and pro-
ssional effects of the "Handicapped" Services Project on the Alabama-Coushatta Indian
servation Head Start Program, inclusive of our students, parents and staff. Services
re almost exclusively on-site, thereby facilitating a greater opportunity for under-
anding between professionals and parents. In addition, case-centered, consultative,
ofessional training was provided for our Staff, exposing new methods and opinions to
. Mainstreaming has been smooth and effective. Finally, and most importantly, the
velopment of these particular Indian children was enriched by the service provided to
em: thorough medical examinations, specialists and other professionals; prescribed
eech therapy for one child with an articulation problem; recommended language classes
r specific children; and an overall reinforcement of the positive elements in the life
each individual child and his cultural background, his education and his own environ-
nt.

A CHECK-UP, ...Hmmm...OK, JUST GLAD I DIDN'T HAVE TO GO TO THE CITY FOR IT...

HELP ME LEARN ...TO TALK ...TO THINK

...LANGUAGE...
NOW THAT WE
KNOW TO TALK AS
WE PLAY, IN
LEARNING CENTERS
FILLED WITH
OUR TOYS...

WE CAN ANSWER
WHO? WHAT? WHY? WHEN?
AND HOW?
...WE CAN THINK...